ACTHAR HP

Products Affected

- Acthar

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	12 months
Other Criteria	For the treatment of multiple sclerosis the patient must have failure, contraindication or intolerance to intravenous corticosteroid therapy and currently maintained on one of the following formulary drugs Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Tecfidera or Rebif before Acthar HP is authorized.

ACTIMMUNE

Products Affected

- Actimmune

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	12 months
Other Criteria	N/A

ALOSETRON

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Alosetron will not be approved for use in men, as safety and efficacy in men has not been established.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Alosetron is considered medically necessary for the treatment of severe IBS-D. At least one of the following must be present for diarrhea to be considered severe: frequent and severe abdominal pain or discomfort, frequent bowel urgency or fecal incontinence, and disability or restriction of daily activities due to IBS.

AMYLIN ANALOG

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Hemoglobin A1C less than 7% prior to initiating Amylin Analog therapy.
Required Medical Information	Documentation of past and current medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The member must have documentation of previous insulin failure and documentation of continuation of insulin therapy concomitantly with the requested drug.

ANABOLIC STEROIDS, ANDROGENS

Products Affected

- Anadrol-50
- Oxandrolone TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ANTIFUNGALS, AZOLE

Products Affected

- Voriconazole INJ
- Voriconazole SUSR
- Voriconazole TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documented fungal culture and/or notes from medical record suggestive of a serious fungal infection. For prophylactic use, fungal culture and medical records are not required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 to 6 months, depending on indication
Other Criteria	For the treatment of oropharyngeal candidiasis, the candidiasis must be refractory to itraconazole or fluconazole.

ANTIFUNGALS, SUPERFICIAL AND SYSTEMIC

Products Affected

- Caspofungin Acetate
- Itraconazole CAPS
- Itraconazole SOLN

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	Onychomycosis (fingernails)-2mo. Onychomycosis (toenails)-3mo. All other indications -12 months
Other Criteria	For the treatment of tinea versicolor or pityriasis, use of oral ketoconazole or a topical antifungal agent is required prior to the use of Itraconazole. For candidiasis infections (unless specified C. glabrata or C. krusei), use of fluconazole is required prior to the use of itraconazole.

ANTIFUNGALS, TRIAZOLE

Products Affected

- Noxafil SUSP
- Noxafil TBEC
- Posaconazole Dr

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	6 months
Other Criteria	For the prophylaxis of invasive Aspergillus and Candida infections: Noxafil (posaconazole)is considered medically necessary in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy. For the treatment of oropharyngeal candidiasis, the candidiasis must be refractory to itraconazole or fluconazole.

ANTINEOPLASTICS, MONOCLONAL ANTIBODIES

Products Affected

- Enhertu
- Kanjinti INJ 420MG
- Lartruvo
- Libtayo
- Mvasi
- Poteligeo
- Rituxan
- Rituxan Hycela

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	12 months
Other Criteria	B vs D coverage determination

APOKYN

Products Affected

- Apokyn INJ 30MG/3ML

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	12 months
Other Criteria	N/A

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All FDA-Approved Indications, Some Medically-Accepted Indications.
Off-Label Uses	Cystic fibrosis pseudomonas aeruginoa infection
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous medication history
Age Restrictions	MAC-18 years and older
Prescriber Restrictions	MAC-Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections. Cystic fibrosis-prescribed by or in consultation with a pulmonologist or physician who specializes in the treatment of cystic fibrosis
Coverage Duration	1 year
Other Criteria	MAC Lung disease-approve if the patient has NOT achieved negative sputum cultures for Mycobacterium avium complex after a background multidrug regimen AND Arikayce will be used in conjunction to a background multidrug regimen. Note-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin). Cystic fibrosis-patient has pseudomonas aeruginosa in culture of the airway.

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and sleep study for the diagnosis of sleep apnea or narcolepsy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the treatment of narcolepsy, the patient must have failure, contraindication, or intolerance to methylphenidate or dextroamphetamine sulfate before armodafinil is authorized.

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Diagnosis Iron deficiency anemia not on dialysis
Required Medical Information	Documentation of dialysis and hyperphosphatemia
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

AUSTEDO

Products Affected

- Austedo

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Chorea associated with Huntington's disease: trial and failure, contraindication, or intolerance to tetrabenazine. For the treatment of tardive dyskinesia, no trial and failure is required

BENLYSTA

Products Affected

- Benlysta INJ 120MG, 400MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent use with other biologics or with cyclophosphamide intravenous (IV)
Required Medical Information	The patient must have a positive autoantibody test (i.e., anti-nuclear antibody [ANA] greater than or equal to 1:80 and/or anti-double-stranded DNA [anti-dsDNA] greater than or equal to 30 IU/ml).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient must be receiving one standard therapy for SLE with any of the following: corticosteroids, hydroxychloroquine, or immunosuppressives (cyclophosphamide, azathioprine, mycophenolate, methotrexate, cyclosporine) AND there must be an absence of severe active lupus nephritis or severe active central nervous system lupus before Benlysta is authorized. B vs D coverage determination.

BEXAROTENE

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Exclude when used for cosmetic purposes.
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months. Continuation: 12 months
Other Criteria	For chronic migraine, the patient has had failure or inadequate response following a minimum 3 month trial, contraindication per FDA label, intolerance, or not a candidate for at least TWO different prescription migraine prevention therapies from different classes of migraine prophylaxis medications: Antiepileptic drugs (ex: divalproex, sodium valproate, topiramate), Antidepressants (ex: amitriptyline, venlafaxine), Beta blockers (ex:metoprolol, propranolol, timolol, atenolol, nadolol) For overactive bladder, the patient has had failure or inadequate response two antimuscarinic medications for OAB (for example: darifenacin, flavoxate, oxybutynin, solifenacin, tolterodine, Toviaz).

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All FDA-approved indications not otherwise excluded from Part D
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Mantle Cell Lymphoma – approve for 3 years if the patient has tried at least one prior therapy.

CARBAGLU

Products Affected

- Carbaglu

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	12 months
Other Criteria	N/A

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Cystic Fibrosis and documentation of Pseudomonas aeruginosa infection.
Age Restrictions	7 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CIALIS

Products Affected

- Cialis TABS 2.5MG, 5MG
- Tadalafil TABS 2.5MG, 5MG

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	12 months
Other Criteria	Cialis (tadalafil) 2.5mg and 5mg are only covered under Part D for the treatment of benign prostatic hyperplasia (BPH). Cialis (tadalafil) can be approved with a non-D authorization for the indication of erectile dysfunction if the EGWP customer has the lifestyle buy-up

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient must have a confirmed diagnosis of HAE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient must have a history of more than one severe event per month. B vs D coverage determination.

CLOMIPHENE

Products Affected

- Clomiphene Citrate 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	12 months
Other Criteria	Clomiphene can be approved with a non-D authorization for the indication of infertility if the EGWP customer has the fertility buy-up

CORLANOR

Products Affected

- Corlanor TABS

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Chronic stable angina, in combination with beta-blocker therapy
Exclusion Criteria	1.) Blood pressure less than 90/50 mmHg. 2.) Sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present. 3.) Resting heart rate less than 60 bpm prior to treatment. 4.) Pacemaker dependence (heart rate maintained exclusively by the pacemaker).
Required Medical Information	Documentation of diagnosis, previous use of a beta-blocker, LVEF, sinus rhythm, resting HR, and blood pressure.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For use in chronic heart failure, the patient must have left ventricular ejection fraction less than or equal to 35%, normal sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, and either be on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use. For use in chronic angina, the patient must be using in combination with maximally tolerated doses of beta-blockers.

CRINONE

Products Affected

- Crinone GEL 8%

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	12 months
Other Criteria	Crinone can be approved with a non-D authorization for the indication of infertility if the EGWP customer has the fertility buy-up

CYSTARAN

Products Affected

- Cystaran

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	12 months
Other Criteria	N/A

DALFAMPRIDINE

Products Affected

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Dalfampridine is considered medically necessary for patients with multiple sclerosis with medical documentation of impaired walking ability.

DEMSER

Products Affected

- Demser

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	12 months
Other Criteria	For intial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin) AND the patient has tried phenoxybenzamine (brand or generic). For continuation of therapy, approve if the patient is currently receiving Demser or has received Demser in the past.

DERMATOLOGICAL RETINOIDS

Products Affected

- Avita
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

DERMATOLOGICAL WOUND CARE AGENTS

Products Affected

- Regranex

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	12 months
Other Criteria	N/A

DIFICID

Products Affected

- Dificid

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	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

DUAVEE

Products Affected

- Duavee

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	12 months
Other Criteria	For the prevention of postmenopausal osteoporosis, trial, failure, or intolerance of raloxifene is required prior to the use of Duavee.

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Indications	All FDA approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Concurrent use with Xolair
Required Medical Information	Diagnosis, prescriber specialty, other medications tried and length of trials
Age Restrictions	asthma/AD-12 years of age and older. Chronic Rhinosinusitis-18 years of age and older
Prescriber Restrictions	Atopic Dermatitis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist
Coverage Duration	AD-Initial-16 weeks, Cont-1 year, asthma/Rhinosinusitis-initial-6 months, cont 1 year
Other Criteria	Atopic Dermatitis-Initial-meets both a and b: a.has used at least one medium, medium-high, high, and/or super-high-potency prescription topical corticosteroid OR has atopic dermatitis affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus ointment AND b.Inadequate efficacy was demonstrated with these previously tried topical prescription therapies, according to the prescribing physician.Continuation-Approve if the pt has responded to Dupixent therapy as determined by the prescribing physician. Asthma-Initial-approve if pt meets the following criteria (i, ii, and iii):i.Pt meets ONE of the following criteria (a or b):a)has a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL) therapy or Xolair OR b)has oral corticosteroid-dependent asthma, per the prescriber AND ii.has received combination therapy with BOTH of the following (a and b): a)An inhaled corticosteroid (ICS) AND b)At least one additional asthma controller/maintenance medication (NOTE:An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy or Xolair used concomitantly with an ICS. Use of a combination inhaler containing both an ICS and a LABA would fulfil the requirement for both criteria a and b) AND iii.asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy or Xolair as defined by ONE of the following (a, b, c, d or e): a)experienced two or more asthma

	exacerbations requiring treatment with systemic corticosteroids in the previous year OR b)experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department visit in the previous year OR c)has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d)has an FEV1/forced vital capacity (FVC) less than 0.80 OR e)The patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation-Approve if meets the following criteria (i and ii): i.continues to receive therapy with one inhaled corticosteroid (ICS) or one ICS-containing combination inhaler AND ii.has responded to Dupixent therapy as determined by the prescribing physician. Chronic rhinosinusitis with Nasal Polyposis-Initial-pt is currently receiving therapy with an intranasal corticosteroid AND is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell according to the prescriber AND meets ONE of the following (a or b): a)has received treatment with a systemic corticosteroid within the previous 2 years or has a contraindication to systemic corticosteroid therapy OR b)has had prior surgery for nasal polyps. Continuation-approve if the pt continues to receive therapy with an intranasal corticosteroid AND pt has responded to Dupixent therapy as determined by the prescriber.

EGRIFTA

Products Affected

- Egrifta INJ 1MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Males must have a waist circumference of at least 95cm (37.5in) and a waist-to-hip ratio of at least 0.94. Females must have a waist circumference of at least 94cm (37in) and a waist-to-hip ratio of at least 0.88. Continuation of therapy approval is contingent upon ONE of the following: 1.) decrease in VAT measured by CT scan or 2.) reduction of waist circumference and waist-to-hip ratio from baseline measurement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient must be on a stable antiretroviral regimen for at least 8 weeks.

ENDOCRINE AND METABOLIC AGENTS

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The patient must have a diagnosis of acromegaly AND had inadequate response to surgery or radiation therapy or documentation these therapies are not appropriate for the patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ENZYME REPLACEMENT/MODIFIERS

Products Affected

- Aldurazyme
- Elaprase
- Naglazyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks, based on indication and established treatment guidelines
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	Documentation of Lennox-Gastaut syndrome or Dravet syndrome
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of locally advanced or metastatic basal cell carcinoma that has recurred following surgery or who are not candidates for surgery, and who are not candidates for radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Erleada is approved for use in combination with a gonadotropin-releasing hormone (GnRH) analog or in patients who have had a bilateral orchiectomy.

EYLEA

Products Affected

- Eylea

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Administered by or under the supervision of an ophthalmologist
Coverage Duration	3 years
Other Criteria	N/A

FERRIPROX

Products Affected

- Ferriprox SOLN
- Ferriprox TABS 500MG

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	12 months
Other Criteria	Initial therapy - approve if prior to starting therapy the serum ferritin level was greater than 2,500 mcg/L. Continuation therapy - approve if the patient is benefiting from therapy as confirmed by the prescribing physician.

FIRAZYR

Products Affected

- Firazyr
- Icatibant Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient must have a confirmed diagnosis of HAE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Firazyr (icatibant) is considered medically necessary for the treatment of acute attacks of hereditary angioedema (HAE) in patients who have tried and failed Ruconest.

FIRDAPSE

Products Affected

- Firdapse

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	12 months
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

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	12 months
Other Criteria	N/A

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 to 24 weeks based on indication and established treatment guidelines
Other Criteria	N/A

HEMATOPOIETICS

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML
- Epogen INJ 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML
- Procrit
- Retacrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For initial treatment of anemia, documentation of Hemoglobin less than 10, transferrin saturation greater than 20%, and ferritin levels greater than 100 obtained over the last 3 months. For patients who do not meet iron store requirements to create red blood cells, approval can be given if evidence shows the patient has started supplemental iron. For continuation of therapy, approvals granted if Hemoglobin does not exceed 11 g/dL for chronic kidney disease anemia, 13g/dL for the indication of reduction of allogeneic red cell transfusions in patients undergoing elective, noncardiac, nonvascular surgery, and 12g/dL for all other indications.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Patients must also have failure, contraindication or intolerance to Retacrit, Procrit or Aranesp before Epogen will be authorized. B vs D coverage determination.

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	A circadian rhythm longer than 24 hours has been confirmed by daily sleep logs and actigraphy for at least 14 days. Documentation that patient is totally blind and lacks light perception.
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HORMONAL AGENTS, GONADOTROPINS

Products Affected

- Chorionic Gonadotropin INJ
- Novarel INJ 10000UNIT
- Pregnyl W/diluent Benzyl Alcohol/nacl

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Chorionic gonadotropin, Novarel and Pregnyl can be approved with a non-D authorization for the indication of infertility if the EGWP customer has the fertility buy-up

HORMONAL AGENTS, SOMATOSTATIN ANALOGS

Products Affected

- Octreotide Acetate
- Sandostatin Lar Depot
- Somatuline Depot

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - ANTIDEMENTIA AGENTS

Products Affected

- Ergoloid Mesylates TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives are: donepezil, galantamine and rivastigmine.

HRM - BENZTROPINE

Products Affected

- Benztropine Mesylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives if two are available or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient. If only one (1) safer formulary alternative is available, then only that particular medication would need to be documented as tried and failed or clinical rationale provided as to why that one safer formulary alternative is not appropriate for the patient. For patients concurrently taking multiple anticholinergeric medications, the physician has assessed the risk.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives depend on indication. For Parkinsonism, safer alternatives are: Carbidopa/Levodopa, Pramipexole, Ropinirole, Bromocriptine, Amantadine, and Selegiline. For extrapyramidal symptoms, a safer alternative is: Amantadine.

HRM - BUTALBITAL COMBINATIONS

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives are: naproxen sodium and ibuprofen.

HRM - CARISOPRODOL

Products Affected

- Carisoprodol TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For patients over 65, the physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects. For patients under 65 requesting carisoprodol, diagnosis is required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - CHLORDIAZEPOXIDE/AMITRIPTYLINE

Products Affected

- Chlordiazepoxide/amitriptyline

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient. For patients concurrently taking multiple anticholinergeric medications, the physican has assessed the risk.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion.

HRM - ESTROGENS

Products Affected

- Alora
- Amabelz
- Climara
- Climara Pro
- Combipatch
- Dotti
- Estradiol ORAL TABS 0.5MG, 1MG, 2MG
- Estradiol PTTW
- Estradiol PTWK
- Estradiol/norethindrone Acetate
- Femhrt Low Dose
- Fyavolv
- Jinteli
- Lopreeza TABS 0.5MG; 0.1MG
- Menostar
- Mimvey
- Mimvey Lo
- Minivelle
- Norethindrone Acetate/ethinyl Estradiol TABS 2.5MCG; 0.5MG, 5MCG; 1MG
- Prefest
- Premarin TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG
- Premphase
- Prempro
- Vivelle-dot

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, Yuvafem and vaginal estradiol tablets. For Bone Density, safer alternatives are: bisphosphonates, raloxifene, and Prolia

HRM - GLYBURIDE

Products Affected

- Glyburide TABS
- Glyburide Micronized

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed glipizide or provided clinical rationale as to why that safer formulary alternative is not appropriate for the patient.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - GLYBURIDE/METFORMIN

Products Affected

- Glucovance TABS 2.5MG; 500MG, 5MG; 500MG
- Glyburide/metformin Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed glipizide-metformin or provided clinical rationale why that safer formulary alternative is not appropriate for the patient.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - MEGESTROL

Products Affected

- Megestrol Acetate SUSP
- Megestrol Acetate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the treatment of cachexia/loss of appetite associated with AIDS (megestrol oral suspension only), the physician has documented that the patient has tried and failed dronabinol or provided clinical rationale as to why that safer formulary alternative is not appropriate for the patient. For all other indications, trial of dronabinol is not required.

HRM - MENEST

Products Affected

- Menest TABS 0.3MG, 0.625MG, 1.25MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative or provided clinical rationale why one safer formulary alternative is not appropriate for the patient. For palliative therapy of metastatic breast cancer, no trial of a formulary alternative is required.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For vasomotor symptoms of menopause, safer alternatives are: SSRIs, venlafaxine, gabapentin, and Femring. For vaginal symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, Yuvafem and vaginal estradiol tablets. For all other indications, no formulary alternative is required.

HRM - METHYLDOPA

Products Affected

- Methyldopa TABS 250MG, 500MG
- Methyldopa/hydrochlorothiazide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives are: ACE inhibitors (ex: Benazepril, Captopril, Enalapril, Lisinopril, Quinapril, and Ramipril), ARBs (ex: Candesartan, Irbesartan, Losartan, and Telmisartan), Beta-blockers (ex: Atenolol, Metoprolol, Nadolol, Pindolol, and Propranolol), Calcium channel blockers (ex: Verapamil, Diltiazem, Amlodipine, Felodipine, and Nifedipine ER), and Thiazide diuretics (ex: Hydrochlorothiazide, Chorthalidone, and Indapamide).

HRM - PERPHENAZINE/AMITRIPTYLINE

Products Affected

- Perphenazine/amitriptyline

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient. For patients concurrently taking multiple anticholinergeric medications, the physican has assessed the risk.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion.

HRM - PROMETHAZINE

Products Affected

- Promethazine Hcl INJ 50MG/ML
- Promethazine Hcl SYRP
- Promethazine Hcl TABS 12.5MG
- Promethazine Hcl Plain
- Promethazine Hydrochloride TABS 25MG, 50MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed two safer formulary alternatives if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient. If only one (1) safer formulary alternative is available, then only that particular medication would need to be documented as tried and failed or clinical rationale provided as to why that one safer formulary alternative is not appropriate for the patient. For patients concurrently taking multiple anticholinergeric medications, the physician has assessed the risk.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For postoperative nausea and vomiting, the safer alternative is ondansetron. For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.

HRM - SKELETAL MUSCLE RELAXANTS

Products Affected

- Carisoprodol/aspirin
- Carisoprodol/aspirin/codeine
- Chlorzoxazone TABS 500MG
- Cyclobenzaprine Hydrochloride TABS
- Metaxall
- Metaxalone
- Methocarbamol TABS
- Orphenadrine Citrate Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects. For patients concurrently taking multiple anticholinergeric medications, the physican has assessed the risk.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - TRICYCLIC ANTIDEPRESSANTS

Products Affected

- Amitriptyline Hcl TABS 100MG, 150MG, 25MG, 75MG
- Amitriptyline Hydrochloride TABS 10MG, 50MG
- Anafranil
- Clomipramine Hcl CAPS
- Doxepin Hcl CAPS 100MG, 10MG, 150MG, 50MG, 75MG
- Doxepin Hcl CONC
- Doxepin Hydrochloride CAPS 25MG
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Imipramine Pamoate
- Trimipramine Maleate CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient. For patients concurrently taking multiple anticholinergeric medications, the physican has assessed the risk.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Escitalopram, Fluvoxamine, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, Rizatriptan and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin. If using requested medication for a medically-accepted indication not listed above, then no trial of alternatives is required.

HRM - TRIHEXYPHENIDYL

Products Affected

- Trihexyphenidyl Hcl SOLN
- Trihexyphenidyl Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects. For patients concurrently taking multiple anticholinergeric medications, the physician has assessed the risk.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HYDROXYPROGESTERONE

Products Affected

- Hydroxyprogesterone Caproate INJ 1.25GM/5ML

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	12 months
Other Criteria	B vs D coverage determination

IDIOPATHIC PULMONARY FIBROSIS

Products Affected

- Esbriet
- Ofev

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	For the diagnosis of IPF, other known causes of interstitial lung disease e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity.
Required Medical Information	Diagnosis of IPF confirmed by 1.) in patients without surgical lung biopsy: Usual interstitial pneumonia (UIP) pattern on high resolution computed tomography (HRCT) is indicative of IPF or 2.) in patients with surgical lung biopsy: The biopsy pattern is diagnostic of IPF or the combination of HRCT and biopsy pattern is indicative of IPF. For use of Ofev in systemic sclerosis-associated interstitial lung disease (SSc-ILD) no further documentation is required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Esbriet and Ofev will each be used as monotherapy.

IMMUNE STIMULANTS

Products Affected

- Adagen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

IMMUNE SUPPRESSANTS

Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick
- Humira
- Humira Pediatric Crohns Disease Starter Pack
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-ps/uv Starter
- Skyrizi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	1.) Use of Humira or Enbrel is considered medically necessary for the treatment of Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least one alternative disease modifying antirheumatic drugs (DMARDs). A previous trial of a biologic also counts as a trial. 2.) Use of Humira or Enbrel is considered medically necessary for the treatment of Juvenile Rheumatoid Arthritis in patients that have tried and failed at least one other agent (e.g. MTX, sulfasalazine, leflunomide, or DMARD) or will be starting on a adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if patient has absolute contraindication to MTX, sulfasalazine, or leflunomide or if patient has aggressive disease. A previous trial of a biologic also counts as a trial. 3.) Use of Humira or Enbrel is considered medically necessary for the treatment of Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. A previous trial of a biologic also counts as a trial. 4.) Use of Humira, Enbrel, or Sykrizi is considered medically necessary for the treatment of Plaque Psoriasis in patients that have: a.) moderate to severe chronic disease, b.) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) OR one systemic agent (e.g. MTX, cyclosporine, etc.) A previous trial of a biologic also counts as a trial.

	5.) Use of Humira or Enbrel is considered medically necessary for the treatment of Psoriatic Arthritis in patients with active disease. 6.) Use of Humira is considered medically necessary for the treatment of moderate to severe Crohn's Disease in patients that have tried and failed at least 1 of the following: immunomodulators, corticosteroids, or aminosalicylates. A previous trial of a biologic also counts as a trial. 7.) Use of Humira is considered medically necessary for the treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 1 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus. A previous trial of a biologic also counts as a trial. 8.) Use of Humira is considered medically necessary for the treatment of hidradenitis suppurativa and uveitis.

IMMUNE SUPPRESSANTS - RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	1.) Rinvoq is considered medically necessary for the treatment of Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least one alternative disease modifying antirheumatic drugs (DMARDs). A previous trial of a biologic also counts as a trial.

IMMUNE SUPPRESSANTS - STELARA

Products Affected

- Stelara INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	1.) Stelara is considered medically necessary for the treatment of Plaque Psoriasis in patients that have: a.) moderate to severe chronic disease, b.) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) OR one systemic agent (e.g. MTX, cyclosporine, etc.). A previous trial of a biologic also counts as a trial. 2.) Stelara is considered medically necessary for the treatment of Psoriatic Arthritis in patients with active disease. 3.) Stelara is considered medically necessary for the treatment of moderate to severe Crohn's Disease in patients that have tried and failed at least 1 of the following: immunomodulators, corticosteroids, or aminosalicylates. A previous trial of a biologic also counts as a trial. 4.) Stelara is considered medically necessary for the treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 1 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus. A previous trial of a biologic also counts as a trial.

IMMUNE SUPPRESSANTS - TRANSPLANT RELATED

Products Affected

- Astagraf XL
- Atgam
- Azasan
- Azathioprine INJ
- Azathioprine TABS
- Cellcept
- Cyclosporine CAPS
- Cyclosporine INJ
- Cyclosporine Modified
- Envarsus Xr
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Hecoria
- Mycophenolate Mofetil
- Mycophenolic Acid Dr
- Myfortic
- Neoral
- Prograf
- Rapamune
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Zortress

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	12 months
Other Criteria	B vs D coverage determination

IMMUNE SUPPRESSANTS - XELJANZ

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	1.) Xeljanz is considered medically necessary for the treatment of Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least one alternative disease modifying antirheumatic drugs (DMARDs). A previous trial of a biologic also counts as a trial. For Rheumatoid Arthritis, dosing 10mg twice a day will not be approved in patients with at least one cardiovascular risk factor. 2.) Xeljanz is considered medically necessary for the treatment of Psoriatic Arthritis in patients with active disease. For Psoriatic Arthritis, dosing 10mg twice a day will not be approved in patients with at least one cardiovascular risk factor. 3.) Xeljanz is considered medically necessary for the treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 1 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus. A previous trial of a biologic also counts as a trial.

IMMUNOMODULATORS

Products Affected

- Aubagio
- Avonex
- Avonex Pen
- Betaseron
- Copaxone INJ 20MG/ML, 40MG/ML
- Extavia
- Gilenya CAPS 0.5MG
- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack
- Tecfidera
- Tecfidera Starter Pack

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Multiple Sclerosis, Clinically Isolated Syndrome (Avonex, Betaseron, Extavia, and Rebif)
Exclusion Criteria	N/A
Required Medical Information	Documentation of a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses), or diagnosis of Clinically Isolated Syndrome.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

INFLIXIMAB

Products Affected

- Renflexis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	1.) Use of Renflexis is considered medically necessary for the treatment of Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least one alternative disease modifying antirheumatic drugs (DMARDs). 2.) Use of Renflexis is considered medically necessary for the treatment of Juvenile Rheumatoid Arthritis in patients that have tried and failed at least one other agent (e.g. MTX, sulfasalazine, leflunomide, or DMARD). Approve without trying another agent if patient has absolute contraindication to MTX, sulfasalazine, or leflunomide or if patient has aggressive disease. 3.) Use of Renflexis is considered medically necessary for the treatment of Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4.) Use of Renflexis is considered medically necessary for the treatment of Plaque Psoriasis in patients that have: a.) moderate to severe chronic disease, b.) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) OR one systemic agent (e.g. MTX, cyclosporine, etc.) 5.) Use of Renflexis is considered medically necessary for the treatment of Psoriatic Arthritis in patients with active disease. 6.) Use of Renflexis is considered medically necessary for the treatment of moderate to severe Crohn's Disease in patients that have tried and

	failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates 7.) Use of Renflexis is considered medically necessary for the treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. 8.) Use of Renflexis is considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D coverage determination required for Renflexis.

INSULIN-LIKE GROWTH FACTOR

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis. Documentation of lab data reflecting height standard deviation score, basal IGF-1 score, and growth hormone level.
Age Restrictions	Patients 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Height standard deviation score must be less than or equal to -3.0 AND the basal IGF-1 score must be below the lower limits of normal for the reporting lab AND the patient must have a normal or elevated growth hormone level (excluding patients with growth hormone gene deletion) AND epiphyses must be confirmed as open in patients greater than or equal to 10 years of age.

INTRAROSA

Products Affected

- Intrarosa

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	12 months
Other Criteria	N/A

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Patients with cystic fibrosis (CF) who are homozygous for the F508del mutation in the CFTR gene. Kalydeco will not be used in combination with Orkambi or Symdeko
Required Medical Information	CF mutation test documenting patient has one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

KINERET

Products Affected

- Kineret

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	For RA: 18 years and older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Treatment of rheumatoid arthritis (RA) in adults and when the following criteria are met: inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., methotrexate (MTX), azathioprine, hydroxychloroquine, penicillamine, sulfasalazine) AND the patient has had failure, contraindication, or intolerance to Enbrel or Humira.

KORLYM

Products Affected

- Korlym

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	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis, Phe concentration
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial Approval: 2 months. Continuation of therapy: 12 months.
Other Criteria	For continuation of therapy: the patient must have responded to a therapeutic trial of Kuvan. Response is defined as a 20% or greater reduction in blood phenylalanine level from baseline.

LIDOCAINE PATCHES

Products Affected

- Lidocaine PTCH

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	12 months
Other Criteria	For the FDA-labeled indication of post-herpetic neuralgia, no additional criteria are required to be met. For diabetic neuropathic pain: the patient must have previous use and inadequate response or intolerance to any ONE medication that is FDA-labeled for diabetic peripheral neuropathy, including duloxetine and Lyrica. For cancer related neuropathic pain (including treatment-related neuropathy), no additional criteria are required to be met. For non-medically accepted indications, lidocaine patches can be approved with a non-D authorization.

LUMIZYME

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	8-16 weeks, based on indication and established treatment guidelines
Other Criteria	N/A

METABOLIC BONE DISEASE AGENTS

Products Affected

- Forteo INJ 600MCG/2.4ML
- Tymlos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Cumulative use of parathyroid hormone analogs for more than 2 years during a patient's lifetime
Required Medical Information	Diagnosis of osteoporosis based on DEXA (T-score less than or equal to -2.5) or based on presence of documented fragility fracture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years from initiation of therapy
Other Criteria	Member has tried and/or failed a bisphosphonate or SERM OR the member has documented intolerance, contraindication, or hypersensitivity to other osteoporosis therapies. For patients with a T-score less than or equal to -3.5, failure of bisphosphonates or SERMs are not required.

METHAMPHETAMINE HCL

Products Affected

- Methamphetamine Hcl

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded when used for exogenous obesity
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient must have failure, contraindication or intolerance to dextroamphetamine, methylphenidate and dexmethylphenidate before methamphetamine hcl is authorized.

MOLECULAR TARGET INHIBITORS

Products Affected

- Abiraterone Acetate
- Afinitor
- Afinitor Disperz
- Alecensa
- Alunbrig
- Balversa
- Bosulif
- Braftovi CAPS 75MG
- Cabometyx
- Calquence
- Caprelsa
- Cometriq
- Copiktra
- Cotellic
- Daurismo
- Erlotinib Hydrochloride
- Everolimus (antineoplastic)
- Farydak
- Gilotrif
- Ibrance
- Iclusig
- Idhifa
- Imatinib Mesylate
- Imbruvica
- Inlyta
- Inrebic
- Iressa
- Jakafi
- Kisqali
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose
- 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
- Lonsurf
- Lorbrena

- Lynparza TABS
- Mekinist
- Mektovi
- Nerlynx
- Nexavar
- Ninlaro
- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose
- Pomalyst
- Rubraca
- Rydapt
- Sprycel
- Stivarga
- Sutent
- Synribo
- Tafinlar
- Tagrisso
- Talzenna
- Tarceva
- Tasigna
- Tibsovo
- Tykerb
- Venclexta
- Venclexta Starting Pack
- Verzenio
- Vizimpro
- Votrient
- Xalkori
- Xospata
- Xpovio 100 Mg Once Weekly
- Xpovio 60 Mg Once Weekly
- Xpovio 80 Mg Once Weekly
- Xpovio 80 Mg Twice Weekly
- Xtandi
- Zejula
- Zelboraf
- Zydelig
- Zykadia
- Zytiga

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	12 months
Other Criteria	N/A

MONOCLONAL ANTIBODIES

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the diagnosis of asthma: Laboratory data reflecting IgE levels greater than 30 IU/mL, medical history documenting previous trial and inadequate response to inhaled corticosteroids and a second controller such as a long-acting beta-agonist or a leukotriene receptor antagonist. For the diagnosis of chronic idiopathic urticaria (CIU): Documentation that the patient has remained symptomatic despite at least 4 weeks of a second generation H1 antihistamine (such as but not limited to levoceterizine or desloratadine) therapy at twice the recommended dosing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Xolair will not be used concomitantly with Cinqair, Dupixent, Fasenra or Nucala

NATPARA

Products Affected

- Natpara

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	12 months
Other Criteria	Chronic hypoparathyroidism, initial therapy - approve if before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician. Chronic hypoparathyroidism, continuing therapy - approve if during Natpara therapy, the patient's 25-hydroxyvitamin D stores are sufficient per the prescribing physician AND the patient is responding to Natapara therapy, as determined by the prescriber.

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	Use will be for treatment of intermittent, stereotypic episodes of frequent seizure activity (for example, seizure clusters, acute repetitive seizures) that are distinct from the individual's usual seizure pattern.
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Individual is currently receiving maintenance antiepileptic medication.

NMDA RECEPTOR ANTAGONIST

Products Affected

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

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	Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- Modafinil
- Provigil

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and sleep study for the diagnosis of sleep apnea or narcolepsy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NON-PREFERRED IMMUNE SUPPRESSANTS

Products Affected

- Cimzia
- Cimzia Starter Kit
- Simponi
- Simponi Aria

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	1.) Use of Cimzia, or Simponi is considered medically necessary for the treatment of Rheumatoid Arthritis in patients that have a.) tried and failed methotrexate OR at least one alternative disease modifying antirheumatic drugs (DMARDs) (note: pts who have already tried a biologic are not required to step back and try a traditional agent first) AND b.) tried and failed Enbrel or Humira. 2.) Use of Cimzia or Simponi is considered medically necessary for the treatment of: Ankylosing Spondylitis in patients that have a.) tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine (note: pts who have already tried a biologic are not required to step back and try a traditional agent first) AND b.) tried and failed Enbrel or Humira. 3.) Use of Cimzia is considered medically necessary for the treatment of: Plaque Psoriasis in patients that have: a.) moderate to severe chronic disease, b.) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) (note: pts who have already tried a biologic are not required to step back and try a traditional agent first) AND d.) tried and failed Enbrel or Humira. 4.) Use of Cimzia or Simponi is considered medically necessary for the treatment of: Psoriatic Arthritis in patients with active disease that have tried and failed Enbrel or Humira. 5.) Use of Cimzia is considered medically necessary for the treatment of: Moderate to severe Crohn's Disease in patients that have a.) tried and

	failed at least 1 of the following: immunomodulators, corticosteroids, or aminosalicylates (note: pts who have already tried a biologic are not required to step back and try a traditional agent first) AND b.) tried and failed Humira. 6.) Use of Simponi is considered medically necessary for the treatment of: moderately to severely active ulcerative colitis in patients who have a.) had inadequate response to at least 1 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine (note: pts who have already tried a biologic are not required to step back and try a traditional agent first) AND b.) tried and failed Humira. 7.) Use of Cimzia is considered medically necessary for the treatment of non-radiographic axial spondyloarthritis in patients that have a.) tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID) (note: pts who have already tried a biologic are not required to step back and try a traditional agent first) AND b.) tried and failed Humira.

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Northera 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	12 months
Other Criteria	The patient must have failure, contraindication or intolerance to fludrocortisone acetate or midodrine.

NUEDEXTA

Products Affected

- Nuedexta

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	12 months
Other Criteria	N/A

NULOJIX

Products Affected

- Nulojix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of Epstein-Barr virus serology and current medication regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Documentation of use in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids. B vs D coverage determination.

NUPLAZID

Products Affected

- Nuplazid

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 Parkinson's disease psychosis: The patient has experienced hallucinations or delusions associated with Parkinson's disease psychosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
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	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
Age Restrictions	18 years and older (initial and continuation therapy)
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial and continuation therapy)
Coverage Duration	6 months initial, 3 years cont.
Other Criteria	Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following:a)Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values b)Positive anti-mitochondrial antibodies (AMAs) c)Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy 2. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels)).

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	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a physician who specializes in the treatment of MS and/or a neurologist
Coverage Duration	1 year
Other Criteria	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the treatment of Locally Advanced Basal Cell Carcinoma: the cancer has recurred following surgery or radiation therapy OR the patient is not a candidate for surgery or radiation therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ORENCIA

Products Affected

- Orencia INJ 125MG/ML, 50MG/0.4ML, 87.5MG/0.7ML
- Orencia Clickject

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	1.) Orencia SC is considered medically necessary for the treatment of Rheumatoid Arthritis in patients that have a.) tried and failed methotrexate OR an alternative disease modifying antirheumatic drugs (DMARDs) AND b.) tried and failed Enbrel or Humira. 2.) Use of Orencia SC is considered medically necessary for the treatment of Juvenile Rheumatoid Arthritis in patients that have a.) tried and failed at least 1 DMARD AND b.) tried and failed Enbrel or Humira. 3.) Use of Orencia SC is considered medically necessary for the treatment of: Psoriatic Arthritis in patients with active disease that have tried and failed Enbrel or Humira.

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Combination use with Symdeko
Required Medical Information	CF mutation test documenting the patient is homozygous for the F508del mutation in the CFTR gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

OSPHENA

Products Affected

- Osphena

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	12 months
Other Criteria	N/A

PADCEV

Products Affected

- Padcev

PA Criteria	Criteria Details
Indications	All FDA-approved indications not otherwise excluded from Part D.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	1 year
Other Criteria	Urothelial carcinoma-approve if the patient has locally advanced or metastatic disease, has previously received a programmed death receptor-1 or programmed death-ligand 1 inhibitor and has previously received platinum containing chemotherapy. B vs D coverage determination

PITUITARY HORMONES

Products Affected

- Eligard
- Genotropin
- Genotropin Miniquick
- Leuprolide Acetate INJ
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)
- Nubeqa
- Synarel
- Trelstar Mixject
- Triptodur

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	12 months
Other Criteria	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Use of Promacta for the treatment of thrombocytopenia is considered medically necessary in: a.) patients with chronic hepatitis C, or b.) patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) that have failed corticosteroid OR intravenous immune globulin (IVIG) therapy OR have had an insufficient response to a splenectomy, or c.) severe aplastic anemia with documentation of inadequate response to previous immunosuppressive therapy (e.g. Atgam, Thymoglobulin, cyclosporine) or being used in combination with standard immunosuppressive therapy.

RELISTOR

Products Affected

- Relistor INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Use of Relistor is considered medically necessary for the treatment of opioid-induced constipation in patients with advanced illnesses who are receiving palliative care AND have tried and failed laxative therapy with lactulose or polyethylene glycol. Relistor is also considered medically necessary for the treatment of opioid-induced constipation in adult patients with chronic non-cancer pain who have tried and failed laxative therapy with lactulose or polyethylene glycol AND Amitiza.

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease (ASCVD) OR Primary Hyperlipidemia (including Heterozygous familial hypercholesterolemia (HeFH)) OR Homozygous Familial Hypercholesterolemia (HoFH) (confirmed by either: Genetic testing or History of untreated low-density lipoprotein cholesterol (LDL-C) greater than 500mg/dl or treated LDL greater than 300mg/dl with either: presence of xanthomas before the age of 10 years or evidence of heterozygous familial hypercholesterolemia in both parents.)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial:6 mo. Cont. of therapy: 12 months
Other Criteria	For ASCVD or Primary Hyperlipidemia (including HeFH): Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal (LDL-C greater than 70 mg/dL) and will be continued on high intensity or maximally tolerated statin therapy while on the PCSK9-inhibitor. Patients intolerant to statins as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried 2 statins (any combination of high or moderate intensity statins) and has experienced skeletal–muscle related symptoms on both agents, no concurrent statin use required. For HoFH: Patient is on high-intensity or maximally tolerated lipid lowering therapy (such as statins and/or ezetimibe), is not at LDL-C level goal (LDL-C greater than 70 mg/dL), and will be continued on high intensity or maximally tolerated lipid lowering therapy while on Repatha. For patients with HoFH who are intolerant to statins, no concurrent statin use required. Continuation of therapy requires documented evidence of clinical benefit response.

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	1. Documentation of metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1-positive. OR 2. Documentation of a solid tumors that has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation. Patient is metastatic or where surgical resection is likely to result in severe morbidity. Patient has no satisfactory alternative treatments or has progressed following treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

RUCONEST

Products Affected

- Ruconest

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Patient must have a confirmed diagnosis of HAE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SAMSCA

Products Affected

- Samsca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Maximum of 30 days for each course of treatment (initial or retreatment)
Other Criteria	Samsca is considered medically necessary for the treatment of patients with significant hypervolemic and euvolemic hyponatremia (serum sodium less than 125 mEq/L) or symptomatic hyponatremia.

SIGNIFOR

Products Affected

- Signifor

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	12 months
Other Criteria	N/A

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record required indicating the patient has multi-drug resistant tuberculosis resistant to isoniazid and rifampin.
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Use of Sirturo for the treatment of multi-drug resistant tuberculosis is considered medically necessary in patients with multi-drug resistant tuberculosis in combination with at least 3 other agents.

SODIUM PHENYLBUTYRATE

Products Affected

- Sodium Phenylbutyrate POWD 3GM/TSP
- Sodium Phenylbutyrate 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	12 months
Other Criteria	N/A

SYLATRON

Products Affected

- Sylatron

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Failure, contraindication, or intolerance to clobazam tablets and oral solution before Sympazan is authorized.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SYNAGIS

Products Affected

- Synagis INJ 100MG/ML, 50MG/0.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	24 months or younger
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

TARGRETIN (TOPICAL)

Products Affected

- Targretin GEL

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis of chorea associated with Huntington's Disease. CYP 2D6 genotype must be provided for doses greater than 50mg/day.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

THALIDOMIDE (THALOMID)

Products Affected

- Thalomid

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	12 months
Other Criteria	N/A

TRANSMUCOSAL FENTANYL CITRATE

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis.
Age Restrictions	16 years of age and older for fentanyl citrate (lozenge/troche)
Prescriber Restrictions	Enrollment in the Transmucosal Immediate-Release Fentanyl (TIRF) REMS Access program.
Coverage Duration	12 months
Other Criteria	Transmucosal fentanyl products will only be covered with documentation of breakthrough cancer pain. The patient must be currently receiving and be tolerant to opioid therapy for persistent cancer pain. The patient must be enrolled in the TIRF REMS Access program.

TYSABRI

Products Affected

- Tysabri

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	12 months
Other Criteria	Treatment of relapsing forms of multiple sclerosis (MS) when EITHER of the following criteria is met: 1.) history of beneficial clinical response to Tysabri (natalizumab) for MS or 2.) failure, contraindication or intolerance to one formulary alternative (eg. Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Tecfidera or Rebif). Treatment of moderately to severely active Crohn's disease (CD) when EITHER of the following criteria is met: 1.) history of beneficial clinical response to Tysabri (natalizumab) for CD or 2.) failure or intolerance to Humira.

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Indications	All FDA approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Patient new to Uptravi therapy must meet a) OR b): a) tried TWO or is currently taking TWO oral therapies for PAH (either alone or in combination) each for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, or epoprostenol injection).

VASODILATORS

Products Affected

- Adempas
- Alyq
- Ambrisentan
- Bosentan
- Opsumit
- Sildenafil Citrate TABS 20MG
- Tadalafil TABS 20MG
- Tracleer

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically accepted Indications.
Off-Label Uses	Secondary Reynaud's phenomenon (sildenafil 20mg), Rebound pulmonary hypertension caused by nitric oxide withdrawal (sildenafil 20mg), Persistent pulmonary hypertension of the newborn (sildenafil 20mg), Eisenmenger's syndrome with WHO functional class III (bosentan, Tracleer)
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension. Adempas will also be approved for chronic thromboembolic pulmonary hypertension.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

VENTAVIS

Products Affected

- Ventavis

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	12 months
Other Criteria	B vs D coverage determination

VIBERZI

Products Affected

- Viberzi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of irritable bowel syndrome with diarrhea.
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient must have a history of failure, contraindication or intolerance to one antidiarrheal drug.

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation of a solid tumors that has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation. Patient is metastatic or where surgical resection is likely to result in severe morbidity. Patient has no satisfactory alternative treatments or has progressed following treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

VIVITROL

Products Affected

- Vivitrol

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	12 months
Other Criteria	For the treatment of alcohol dependence, the patient must have failure, contraindication, or intolerance to oral naltrexone hcl before Vivitrol is authorized.

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Treatment naive patients (exception: treatment-naïve patients with genotype 3 with compensated cirrhosis and a Y93H mutation will be approved)
Required Medical Information	Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks, based on indication and established treatment guidelines
Other Criteria	N/A

XATMEP

Products Affected

- Xatmep

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	12 months
Other Criteria	N/A

XENICAL

Products Affected

- Xenical

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	12 months
Other Criteria	For hyperlidemia, the patient is on a maximally tolerated statin and a secondary cholesterol lowering drug. Patients intolerant to statins as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried 2 statins (any combination of high or moderate intensity statins) and has experienced skeletal–muscle related symptoms on both agents, no concurrent statin use required. Xenical can be approved with a non-D authorization for the indication of weight loss if the EGWP customer has the weight loss buy-up

XGEVA

Products Affected

- Xgeva

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	12 months
Other Criteria	For initial therapy in the treatment of hypercalcemia of malignancy: trial and failure, contraindication, or intolerance to one intravenous bisphosphonate (e.g. pamidronate, zoledronic acid) is required. For continuation of therapy in the treatment of hypercalcemia of malignancy, approve if patient has already been started on Xgeva. For other medically accepted indication, no trial of alternatives is required.

XIAFLEX

Products Affected

- Xiaflex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Xiaflex is authorized for the treatment of a symptomatic Dupuytren's contracture in adults when there is both a palpable cord and a functional impairment as manifested by a metacarpophalangeal (MCP) joint or proximal interphalangeal (PIP) joint contracture of 20 degrees or greater.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

XIFAXAN

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the diagnosis of Traveler's Diarrhea, customer has previous treatment, intolerance or contraindication to ciprofloxacin, levofloxacin, ofloxacin or azithromycin. For all other diagnoses, no additional criteria are required to be met.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For diagnosis for Traveler's Diarrhea: 1 month. All other indications: 12 months
Other Criteria	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	The patient must not be taking any sedative hypnotic agents or other CNS depressants.
Required Medical Information	Documentation of diagnosis, sleep study
Age Restrictions	7 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the initial treatment of excessive daytime sleepiness (EDS) in patients with narcolepsy: trial and failure, contraindication, or intolerance to one CNS stimulant (e.g., methylphenidate, dexmethylphenidate, dextroamphetamine) or armodafinil is required. For continuation of therapy in the treatment of excessive daytime sleepiness (EDS) in patients with narcolepsy, approve if patient has already been started on Xyrem. For other medically accepted indication, no trial of alternatives is required.

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Documentation from medical records of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Yonsa is approved for use in combination with methylprednisolone for treatment of metastatic castration-resistant prostate cancer. The patient must have a history of failure, intolerance, or contraindication to Zytiga (abiraterone) and Xtandi before Yonsa will be authorized.

PART B VERSUS PART D

Products Affected

- Abelcet
- Abraxane
- Acetylcysteine SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU
- Alimta
- Aliqopa
- Ambisome
- Aminosyn INJ 148MEQ/L; 1280MG/100ML; 980MG/100ML; 1280MG/100ML; 300MG/100ML; 720MG/100ML; 940MG/100ML; 720MG/100ML; 400MG/100ML; 440MG/100ML; 860MG/100ML; 420MG/100ML; 520MG/100ML; 160MG/100ML; 44MG/100ML; 800MG/100ML, 90MEQ/L; 1100MG/100ML; 850MG/100ML; 35MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 340MG/100ML; 380MG/100ML; 750MG/100ML; 370MG/100ML; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn 7%/electrolytes INJ 124MEQ/L; 900MG/100ML; 690MG/100ML; 96MEQ/L; 900MG/100ML; 210MG/100ML; 510MG/100ML; 660MG/100ML; 510MG/100ML; 10MEQ/L; 280MG/100ML; 310MG/100ML; 30MMOLE/L; 65MEQ/L; 610MG/100ML; 300MG/100ML; 65MEQ/L; 370MG/100ML; 120MG/100ML; 44MG/100ML; 560MG/100ML

- Aminosyn 8.5%/electrolytes INJ 142MEQ/L; 1100MG/100ML; 850MG/100ML; 98MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 10MEQ/L; 340MG/100ML; 380MG/100ML; 30MEQ/L; 65MEQ/L; 750MG/100ML; 370MG/100ML; 65MEQ/L; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 405MG/100ML; 750MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 38MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 8.5%/electrolytes
- Aminosyn M INJ 65MEQ/L; 448MG/100ML; 343MG/100ML; 40MEQ/L; 448MG/100ML; 105MG/100ML; 252MG/100ML; 329MG/100ML; 252MG/100ML; 3MEQ/L; 140MG/100ML; 154MG/100ML; 3.5MMOLE/L; 13MEQ/L; 300MG/100ML; 147MG/100ML; 40MEQ/L; 182MG/100ML; 56MG/100ML; 31MG/100ML; 280MG/100ML

- Aminosyn-hbc INJ 7.1MEQ/100ML; 660MG/100ML; 507MG/100ML; 660MG/100ML; 154MG/100ML; 789MG/100ML; 1576MG/100ML; 265MG/100ML; 206MG/100ML; 1.12GM/100ML; 228MG/100ML; 448MG/100ML; 221MG/100ML; 272MG/100ML; 88MG/100ML; 33MG/100ML; 789MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Aminosyn-rf INJ 113MEQ/L; 600MG/100ML; 429MG/100ML; 462MG/100ML; 726MG/100ML; 535MG/100ML; 726MG/100ML; 726MG/100ML; 330MG/100ML; 165MG/100ML; 528MG/100ML
- Amphotericin B INJ
- Aprepitant
- Aralast Np INJ 1000MG, 500MG
- Arsenic Trioxide INJ
- Avastin
- Bavencio
- Bendeka
- Besponsa
- Bivigam INJ 5GM/50ML
- Bortezomib
- Brovana
- Budesonide SUSP
- Busulfan
- Busulfex
- Carnitor INJ
- Cerezyme
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 25%

- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinimix E 2.75%/dextrose 10% INJ 570MG/100ML; 317MG/100ML; 33MG/100ML; 10GM/100ML; 283MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 25%
- Clinimix N14g30e
- Clinimix N9g15e
- Clinisol Sf 15%
- Cosmegen
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide INJ
- Cyramza
- Dactinomycin
- Daptomycin
- Darzalex
- Daunorubicin Hydrochloride
- Dextrose INJ 50%
- Dextrose 10%/nacl 0.45%
- Dextrose 5% /electrolyte #48 Viaflex
- Dextrose 10%
- Dextrose 10%/nacl 0.2%
- Dextrose 2.5%/nacl 0.45%
- Dextrose 20%
- Dextrose 25% INJ 250MG/ML
- Dextrose 30%
- Dextrose 40%
- Dextrose 5%/lactated Ringers
- Dextrose 50%
- Dronabinol
- Duramorph

- Emend SUSR
- Engerix-b
- Etoposide INJ 100MG/5ML, 1GM/50ML, 500MG/25ML
- Evomela
- Fabrazyme
- Faslodex INJ 250MG/5ML
- Fentanyl Citrate INJ 1000MCG/20ML, 100MCG/2ML, 2500MCG/50ML, 250MCG/5ML
- Firmagon
- Flebogamma Dif
- Fludarabine Phosphate
- Folotyn
- Freamine Hbc 6.9%
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Fulvestrant
- Gamastan
- Gamastan S/d
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked
- Gammaplex INJ 10GM/200ML, 2.5GM/50ML, 5GM/100ML
- Gamunex-c
- Gazyva
- Gemcitabine
- Gemcitabine Hcl
- Gemcitabine Hydrochloride INJ 1GM, 1GM/26.3ML, 200MG/2ML, 200MG/5.26ML, 2GM/20ML, 2GM/52.6ML
- Granisetron Hcl INJ 1MG/ML

- Granisetron Hcl TABS
- Granisetron Hydrochloride
- Hepatamine
- Herceptin
- Herceptin Hylecta
- Hizentra
- Imfinzi
- Imovax Rabies (h.d.c.v.)
- Infugem
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Irinotecan INJ 100MG/5ML, 500MG/25ML
- Irinotecan Hcl
- Irinotecan Hydrochloride
- Istodax (overfill)
- Kabiven
- Kadcyla
- Kcl 0.075%/d5w/nacl 0.45%
- Kcl 0.15%/d5w/nacl 0.2%
- Kcl 0.15%/d5w/nacl 0.225% INJ 5%; 20MEQ/L; 0.225%
- Kcl 0.15%/d5w/nacl 0.45%
- Kcl 0.15%/d5w/nacl 0.9%
- Kcl 0.3%/d5w/nacl 0.45%
- Kcl 0.3%/d5w/nacl 0.9%
- Keytruda INJ 100MG/4ML
- Kyprolis
- Lactated Ringers INJ 3MEQ/L; 109MEQ/L; 28MEQ/L; 4MEQ/L; 130MEQ/L
- Lactated Ringers Viaflex
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride
- Lumoxiti
- Magnesium Sulfate INJ 20GM/500ML, 2GM/50ML, 40GM/1000ML, 4GM/100ML, 4GM/50ML, 50%

- Magnesium Sulfate In D5w INJ 5%; 1GM/100ML
- Melphalan Hydrochloride
- Mesna
- Morphine Sulfate INJ 0.5MG/ML, 10MG/ML, 150MG/30ML, 1MG/ML, 2MG/ML, 4MG/ML, 5MG/ML, 8MG/ML
- Mylotarg
- Nebupent
- Nephramine
- Normosol -r
- Normosol-m In D5w
- Normosol-r
- Normosol-r In D5w
- Nutrilipid
- Octagam INJ 10GM/100ML, 10GM/200ML, 1GM/20ML, 2.5GM/50ML, 20GM/200ML, 2GM/20ML, 5GM/100ML, 5GM/50ML
- Ondansetron Hcl SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Opdivo
- Paclitaxel INJ 100MG/16.7ML, 150MG/25ML, 300MG/50ML, 30MG/5ML
- Palonosetron Hydrochloride INJ 0.25MG/5ML
- Pamidronate Disodium
- Perforomist
- Perikabiven
- Perjeta
- Plenamine
- Potassium Chloride INJ 10MEQ/100ML, 20MEQ/100ML, 2MEQ/ML, 40MEQ/100ML
- Potassium Chloride/dextrose INJ 5%; 20MEQ/L, 5%; 40MEQ/L
- Potassium Chloride/dextrose/lactated Ringers

- Potassium Chloride/dextrose/sodium Chloride
- Potassium Chloride/sodium Chloride INJ 20MEQ/L; 0.45%, 20MEQ/L; 0.9%, 40MEQ/L; 0.9%
- Premasol
- Privigen
- Procalamine
- Prolastin-c
- Prosol
- Pulmozyme
- Rabavert
- Recombivax Hb
- Remodulin
- Ringers Injection INJ 4.5MEQ/L; 156MEQ/L; 4MEQ/L; 147MEQ/L
- Romidepsin
- Simulect
- Sivextro INJ
- Sodium Lactate INJ 5MEQ/ML
- Tecentriq
- Temsirolimus
- Thiotepa INJ 15MG
- Tobramycin NEBU
- Toposar INJ 100MG/5ML, 1GM/50ML, 500MG/25ML
- Torisel
- Tpn Electrolytes
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Treanda INJ 100MG, 25MG
- Treprostinil
- Trisenox INJ 12MG/6ML
- Trogarzo
- Trophamine
- Tyvaso
- Tyvaso Refill

- Tyvaso Starter
- Unituxin
- Vectibix INJ 100MG/5ML, 400MG/20ML
- Velcade
- Vincasar Pfs
- Vincristine Sulfate INJ
- Vinorelbine Tartrate
- Vyxeos
- Yervoy
- Yondelis
- Yupelri
- Zemaira
- Zoledronic Acid INJ 4MG/5ML, 5MG/100ML

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.

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