

# ACTHAR

## Products Affected

- ACTHAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Coverage is not provided for diagnostic procedure.
<b>Required Medical Information</b>	Diagnosis, prescriber or consulting physician specialty, previous medications tried and response
<b>Age Restrictions</b>	Infantile spasms- less than 2yo. Acute MS exac-adult
<b>Prescriber Restrictions</b>	Infantile spasms, prescr/consult w/neurolo/epileptologist.MS exacerbation, prescr/consult w/neuro/phys specializes MS.RA, JIA/JRA, AS, PsA, SLE, Systemic Dermatomyositis, prescr/consult w/rheum.Severe Erythema Multiforme, prescr/consult w/derm.Serum Sickness,prescr/consult w/allergist.Severe acute/chronic allergic/inflamm processes of eye and its adnexa, prescr/consult w/ ophthalmologist.Symptomatic Sarcoidosis, prescr/consult w/pulm/cardio.Nephrotic Syndrome, prescr/consult w/nephrologist.
<b>Coverage Duration</b>	All diagnoses-1 month
<b>Other Criteria</b>	For acute MS exacerbation, approve if Acthar is NOT being used as pulse therapy on a monthly basis. For all other FDA approved diagnoses (other than Infantile spasms or MS exacerbation), approve if the patient has tried a systemic corticosteroid for the current condition and patient has experienced a severe adverse effect or treatment failure with the corticosteroid (e.g., a psychotic reaction).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ACTIMMUNE

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## Products Affected

- ACTIMMUNE

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

# ADEMPAS

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## Products Affected

- ADEMPAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# AIMOVIG

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## Products Affected

- AIMOVIG AUTOINJECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination therapy with Ajovy, Vyepti or Emgality
<b>Required Medical Information</b>	Diagnosis, number of migraine headaches per month, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and has had inadequate responses to those therapies or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# AJOVY

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## Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination therapy with Aimovig, Vyepti or Emgality
<b>Required Medical Information</b>	Diagnosis, number of migraine headaches per month, prior therapies tried
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least one standard prophylactic pharmacologic therapy (e.g., anticonvulsant, beta-blocker) and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ALDURAZYME

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## Products Affected

- ALDURAZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient alpha-L-iduronidase activity in leukocytes, fibroblasts, plasma, or serum OR has a molecular genetic test demonstrating alpha-L-iduronidase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ALOSETRON

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## Products Affected

- *alose tron*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Alosetron will not be approved for use in men, as safety and efficacy in men has not been established.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ALPHA 1 PROTEINASE INHIBITORS

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## Products Affected

- ARALAST NP
- PROLASTIN-C
- ZEMAIRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease)-approve if the patient has a baseline (pretreatment) AAT serum concentration of less than 80 mg/dL or 11 micromol/L.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# AMBRISENTAN

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## Products Affected

- *ambrisentan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) WHO Group 1-results of right heart cath
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For treatment of pulmonary arterial hypertension, ambrisentan must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ANABOLIC STEROIDS

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## Products Affected

- *oxandrolone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients w/Turner's Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia

# ANTIBIOTICS (INJECTABLE)

## Products Affected

- *amikacin injection solution 1,000 mg/4 ml, 500 mg/2 ml*
- *ampicillin sodium*
- *ampicillin-sulbactam*
- *azithromycin intravenous*
- *aztreonam*
- BICILLIN L-A
- CEFEPIME INTRAVENOUS
- *cefotaxime injection recon soln 2 gram*
- CEFOTETAN IN DEXTROSE, ISO-OSM
- *cefotetan injection*
- *cefoxitin*
- *cefoxitin in dextrose, iso-osm*
- *ceftazidime*
- CEFTAZIDIME IN D5W
- *cefuroxime sodium injection recon soln 750 mg*
- *cefuroxime sodium intravenous*
- *ciprofloxacin in 5 % dextrose*
- CLINDAMYCIN IN 0.9 % SOD CHLOR
- *clindamycin in 5 % dextrose*
- *clindamycin phosphate injection*
- *clindamycin phosphate intravenous solution 600 mg/4 ml*
- COLISTIN (COLISTIMETHATE NA)
- *doxy-100*
- *doxycycline hyclate intravenous*
- ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG
- *gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml*
- GENTAMICIN IN NAACL (ISO-OSM) INTRAVENOUS PIGGYBACK 100 MG/50 ML, 120 MG/100 ML
- *gentamicin injection solution 40 mg/ml*
- *gentamicin sulfate (ped) (pf)*
- *levofloxacin in d5w*
- *levofloxacin intravenous*
- *lincomycin*
- *linezolid in dextrose 5%*
- *linezolid-0.9% sodium chloride*
- *metro i.v.*
- *metronidazole in nacl (iso-os)*
- MOXIFLOXACIN-SOD.ACE,SUL-WATER
- *moxifloxacin-sod.chloride(iso)*
- *nafcillin in dextrose iso-osm*
- *nafcillin injection*
- *nafcillin intravenous recon soln 2 gram*
- NUZYRA INTRAVENOUS
- ORBACTIV
- *oxacillin injection*
- *penicillin g potassium*
- *pfizerpen-g*
- *polymyxin b sulfate*
- SIVEXTRO INTRAVENOUS
- STREPTOMYCIN
- *sulfamethoxazole-trimethoprim intravenous*
- SYNERCID
- *tazicef*
- TEFLARO
- *tigecycline*
- *tobramycin sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ANTIFUNGALS (IV)

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## Products Affected

- *casprofungin*
- *fluconazole in nacl (iso-osm)*
- *voriconazole intravenous*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ANTIFUNGALS, POLYENE

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## Products Affected

- ABELCET
- AMBISOME
- *amphotericin b*
- *amphotericin b liposome*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	B vs D coverage determination
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ANTINEOPLASTICS, MONOCLONAL ANTIBODIES

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## Products Affected

- ABRAXANE
- ADCETRIS
- ALIMTA
- ALIQOPA
- BAVENCIO
- BESPONSA
- BLENREP
- BORTEZOMIB INTRAVENOUS
- CYRAMZA
- DANYELZA
- DARZALEX
- DARZALEX FASPRO
- ELZONRIS
- EMPLICITI
- ENHERTU
- EVOMELA
- GAZYVA
- HALAVEN
- IMFINZI
- JEMPERLI
- KADCYLA
- KEYTRUDA
- KIMMTRAK
- LIBTAYO
- LUMOXITI
- MARGENZA
- MONJUVI
- MYLOTARG
- ONIVYDE
- OPDIVO
- OPDUALAG
- *paclitaxel protein-bound*
- PADCEV
- PERJETA
- PHESGO
- POLIVY
- POTELIGEO
- RUXIENCE
- RYBREVAANT
- SARCLISA
- TECENTRIQ
- *thiotepa*
- TIVDAK
- TRAZIMERA
- TRODELVY
- UNITUXIN
- VECTIBIX
- VELCADE
- YERVOY
- YONDELIS
- ZEPZELCA
- ZIRABEV
- ZYNLONTA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	B vs D coverage determination
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# ARANESP

## Products Affected

- ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (IN POLYSORBATE) INJECTION SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Anemia w/CRF not on dialysis. A hemoglobin (Hb) of less than 10.0 g/dL for adults and less than or equal to 11 g/dL for children required for start, Hb has to be less than or equal to 11.5 g/dL adults or less than or equal to 12 g/dL in children if previously receiving epoetin alfa (EA), Mircerca or Aranesp. Anemia due to myelosuppressive chemotx, Hb is 10.0 g/dL or less to start or less than or equal to 12.0 g/dL if previously on EA or Aranesp AND currently receiving myelosuppressive chemo. MDS, approve tx if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. If the pt has previously been receiving Aranesp or EA, approve only if Hb is 12.0 g/dL or less. All conds, deny if Hb exceeds 12.0 g/dL.
<b>Age Restrictions</b>	MDS anemia = 18 years of age and older.
<b>Prescriber Restrictions</b>	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
<b>Coverage Duration</b>	Anemia w/myelosupp=6 mos, Anemia CKD(dialysis)-3 years, no dialysis, MDS-1 year, Other=6 mos.
<b>Other Criteria</b>	For anemia associated with CRF in patients on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundled payment benefit).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Anemia due to myelodysplastic syndrome (MDS)

# ARCALYST

## Products Affected

- ARCALYST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent biologic therapy
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	CAPS-3 mos initial, 3 years cont. DIRA-6 mos initial, 3 years cont. Pericard-3 mos initial, 1 yr cont
<b>Prescriber Restrictions</b>	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist. DIRA initial-rheum, geneticist, dermatologist, or a physician specializing in the treatment of autoinflammatory disorders. Pericarditis-cardiologist or rheum
<b>Coverage Duration</b>	CAPS-3 mos initial, 3 years cont. DIRA-6 mos initial, 3 years cont. Pericard-3 mos initial, 1 yr cont
<b>Other Criteria</b>	CAPS renewal - approve if the patient has had a response as determined by the prescriber. DIRA initial-approve if the patient weighs at least 10 kg, genetic test confirms a mutation in the IL1RN gene and the patient has demonstrated a clinical benefit with anakinra subcutaneous injection. DIRA cont-approve if the patient has responded to therapy. Pericarditis initial-approve if the patient has recurrent pericarditis AND for the current episode, the patient is receiving standard treatment or standard treatment is contraindicated. Continuation-approve if the patient has had a clinical response.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ARIKAYCE

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## Products Affected

- ARIKAYCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous medication history
<b>Age Restrictions</b>	MAC-18 years and older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Cystic fibrosis pseudomonas aeruginosa infection

# ARMODAFINIL

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## Products Affected

- *armodafinil*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Excessive sleepiness associated with Shift Work Sleep Disorder (SWSD) - approve if the patient is working at least 5 overnight shifts per month. Excessive daytime sleepiness associated with obstructive sleep apnea/hypoapnea syndrome-approve. Excessive daytime sleepiness associated with Narcolepsy-approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ATYPICAL ANTIPSYCHOTIC

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## Products Affected

- FANAPT
- LYBALVI
- *paliperidone*
- VRAYLAR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has tried two of the following: olanzapine, quetiapine fumarate, risperidone, ziprasidone. Approve requests for paliperidone ER in Schizoaffective Disorder without the trial of other treatment.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# AUBAGIO

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## Products Affected

- AUBAGIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Information</b>	Relapsing form of MS, to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# AUSTEDO

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## Products Affected

- AUSTEDO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a psychiatrist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# AVONEX

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## Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE
- AVONEX INTRAMUSCULAR SYRINGE KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# BENLYSTA

## Products Affected

- BENLYSTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with other biologics
<b>Required Medical Information</b>	Diagnosis, medications that will be used in combination, autoantibody status
<b>Age Restrictions</b>	18 years and older (initial).
<b>Prescriber Restrictions</b>	SLE-Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation). Lupus Nephritis-nephrologist or rheum. (Initial/cont)
<b>Coverage Duration</b>	SLE-Initial-4 months, cont-3 years. Lupus Nephritis-6 mo initial, 1 year cont
<b>Other Criteria</b>	Lupus Nephritis Initial-approve if the patient has autoantibody-positive SLE (i.e., positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]). Cont-approve if the patient has responded to the requested medication. SLE-Initial-The patient has autoantibody-positive SLE (i.e., positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]) AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician AND The patient has responded to Benlysta as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# BESREMI

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## Products Affected

- BESREMI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use with other interferon products
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or an oncologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial, patient has tried Pegasys unless patient has experienced treatment failure, intolerance, or therapy is contraindicated. For continuation of therapy, approve if patient has already been started on Besremi.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# BETASERON

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## Products Affected

- BETASERON SUBCUTANEOUS KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# BEXAROTENE (ORAL)

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## Products Affected

- *bexarotene*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# BOSENTAN

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## Products Affected

- *bosentan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For treatment of pulmonary arterial hypertension, bosentan must be prescribed by or in consultation with a cardiologist or a pulmonologist. CTEPH-prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	CTEPH - pt must have tried Adempas, has a contraindication to Adempas, or is currently receiving bosentan for CTEPH. Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chronic thromboembolic pulmonary hypertension (CTEPH) (bosentan)

# BOTOX

## Products Affected

- BOTOX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platysmal bands, rejuvenation of the peri-orbital region)
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Migraine headache prophylaxis in patients with chronic migraine if prescribed by, or after consultation with, a neurologist or HA specialist
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	Blepharospasm Associated with Dystonia or Strabismus-approve. Cervical Dystonia (spasmodic torticollis)-approve. Hyperhidrosis, primary axillary-approve. Chronic low back pain after trial with at least 2 other pharmacologic therapies (eg, NSAID, antispasmodics, muscle relaxants, opioids, antidepressants) and if being used as part of a multimodal therapeutic pain management program. Essential tremor after a trial with at least 1 other pharmacologic therapy (eg, primidone, propranolol, benzodiazepines, gabapentin, topiramate). Migraine Headache Prophylaxis in patients with Chronic migraine -must have 15 or more migraine headache days per month with headache lasting 4 hours per day or longer (prior to initiation of Botox therapy) AND have tried at least two other prophylactic pharmacologic therapies, each from a different pharmacologic class (e.g., beta-blocker, anticonvulsant, tricyclic antidepressant). Urinary incontinence associated with a neurological condition (e.g., spinal cord injury, multiple sclerosis) approve after a trial with at least one other pharmacologic therapy (e.g., anticholinergic medication). Overactive Bladder with symptoms of Urge Urinary Incontinence, Urgency and Frequency-approve if the patient has tried at least one other pharmacologic therapy. Spasticity, lower limb-approve. Spasticity, upper limb-approve
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	<p>Achalasia, Anal Fissure (anal sphincter), Chronic facial pain/pain associated with TMJ dysfunction, Chronic low back pain, Hyperhidrosis (Palmar/Plantar, facial), Myofascial pain, Sialorrhea (chronic), Spasticity (other than lower and upper limb (eg, due to cerebral palsy, stroke, brain injury, spinal cord injury, MS, hemifacial spasm)), Essential tremor, Dystonia other than cervical (eg, focal dystonias, tardive dystonia, anismus, laryngeal dystonia/spasmodic dysphonia), Frey's syndrome (gustatory sweating), Ophthalmic disorders (other than blepharospasm or Strabismus (eg, esotropia, exotropia, nystagmus, facial nerve paresis))</p>

# CARBAGLU

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## Products Affected

- CARBAGLU
- *carglumic acid*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist or a specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
<b>Other Criteria</b>	Approve if genetic testing confirmed a mutation leading to N-acetylglutamate synthase deficiency (NAGS) or if the patient has hyperammonemia.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) (generic carglumic acid)



# CAYSTON

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## Products Affected

- CAYSTON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has <i>Pseudomonas aeruginosa</i> in culture of the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CEREZYME

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## Products Affected

- CEREZYME INTRAVENOUS RECON  
SOLN 400 UNIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorder
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Gaucher Disease, Type 1-approve if there is demonstration of deficient beta-glucocerebrosidase activity in leukocytes or fibroblasts OR molecular genetic testing documenting glucocerebrosidase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CHEMET

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## Products Affected

- CHEMET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Blood lead level
<b>Age Restrictions</b>	Approve in patients between the age of 12 months and 18 years
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a professional experienced in the use of chelation therapy (eg, a medical toxicologist or a poison control center specialist)
<b>Coverage Duration</b>	Approve for 2 months
<b>Other Criteria</b>	Approve if Chemet is being used to treat acute lead poisoning (not as prophylaxis) and prior to starting Chemet therapy the patient's blood lead level was greater than 45 mcg/dL.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CHORIONIC GONADOTROPIN

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## Products Affected

- CHORIONIC GONADOTROPIN, HUMAN INTRAMUSCULAR
- NOVAREL
- PREGNYL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CIALIS

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## Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG • *tadalafil oral tablet 2.5 mg, 5 mg*

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

# CLOBAZAM

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## Products Affected

- *clobazam*
- SYMPAZAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications tried
<b>Age Restrictions</b>	2 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Lennox-Gastaut Syndrome, initial therapy-patient has tried one of the following: lamotrigine, topiramate, rufinamide, felbamate, or Epidiolex. Treatment refractory seizures/epilepsy, initial therapy-patient has tried and/or is concomitantly receiving at least two other antiepileptic drugs (e.g., valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, felbamate). Continuation-prescriber confirms patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Dravet Syndrome and treatment-refractory seizures/epilepsy

# CLOMIPHENE

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## Products Affected

- *clomiphene citrate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Clomiphene can be approved with a non-D authorization for the indication of infertility if the EGWP customer has the fertility buy-up
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# COPAXONE

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## Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# CORLANOR

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## Products Affected

- CORLANOR ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Previous use of a Beta-blocker, LVEF
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Chronic HF, adults- must have LVEF of less than or equal 35 percent (currently or prior to initiation of Corlanor therapy) AND tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol, carvedilol ER) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia). Heart failure due to dilated cardiomyopathy, children-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# CRINONE

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## Products Affected

- CRINONE VAGINAL GEL 8 %

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Crinone can be approved with a non-D authorization for the indication of infertility if the EGWP customer has the fertility buy-up
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# CYSTEAMINE (OPHTHALMIC)

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## Products Affected

- CYSTARAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has corneal cysteine crystal deposits confirmed by slit-lamp examination
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# DALFAMPRIDINE

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## Products Affected

- *dalfampridine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older (initial and continuation therapy)
<b>Prescriber Restrictions</b>	MS. If prescribed by, or in consultation with, a neurologist or MS specialist (initial and continuation).
<b>Coverage Duration</b>	Initial-4months, Continuation-1 year.
<b>Other Criteria</b>	Initial-approve if the requested medication is being used to improve or maintain mobility in a patient with MS. Continuation-approve if the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has responded to or is benefiting from therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# DEFERIPRONE

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## Products Affected

- *deferiprone*
- FERRIPROX
- FERRIPROX (2 TIMES A DAY)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Serum ferritin level
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year
Other Criteria	Iron overload, chronic-transfusion related due to thalassemia syndrome or related to sickle cell disease or other anemias - Initial therapy - approve. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

# DERMATOLOGICAL WOUND CARE AGENTS

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## Products Affected

- REGRANEX

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

# DIMETHYL FUMARATE

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## Products Affected

- *dimethyl fumarate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# DUAVEE

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## Products Affected

- DUAVEE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For the prevention of postmenopausal osteoporosis, trial, failure, or intolerance of raloxifene is required prior to the use of Duavee.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# DUPIXENT

## Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody.
<b>Required Medical Information</b>	Diagnosis, prescriber specialty, other medications tried and length of trials
<b>Age Restrictions</b>	AD-6 years and older, asthma-6 years of age and older. Chronic Rhinosinusitis-18 years of age and older
<b>Prescriber Restrictions</b>	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. Rhinosinusitis-prescribed by or in consultation with an allergist, immunologist or otolaryngologist.
<b>Coverage Duration</b>	AD-Initial-4 months, Cont-1 year, asthma/Rhinosinusitis-initial-6 months, continuation 1 year
<b>Other Criteria</b>	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

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>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.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ELAPRASE

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## Products Affected

- ELAPRASE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has laboratory test demonstrating deficient iduronate-2-sulfatase activity in leukocytes, fibroblasts, or plasma OR a molecular genetic test demonstrating iduronate-2-sulfatase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ENBREL

## Products Affected

- ENBREL
- ENBREL SURECLICK
- ENBREL MINI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	PP-4 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Initial only-RA/AS/JIA/JRA,prescribed by or in consult w/ rheum. PsA, prescribed by or in consultation w/ rheumatologist or dermatologist.PP, prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center. Uveitis, prescribed by or in consultation with an ophthalmologist.
<b>Coverage Duration</b>	FDA dx-6 mo init, 3 yrs cont, uveitis init-3 mo, cont-12 mo.GVHD-3 mo
<b>Other Criteria</b>	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA-initial-approve if the patient meets ONE of the following: patient has tried one other medication for this condition (Note: Examples of other medications for JIA include methotrexate, sulfasalazine, or leflunomide, a nonsteroidal anti-inflammatory drug (NSAID). A previous trial of a biologic or JAK inhibitor also counts as a trial of one medication.) OR Patient has aggressive disease. PP initial, approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. Uveitis initial, tried one of the following: periocular, intraocular, or systemic corticosteroid, immunosuppressives or other biologic therapy. GVHD, approve. Continuation-approve if the patient has had a response as determined by the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity

<b>PA Criteria</b>	<b>Criteria Details</b>
	limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Graft versus host disease (GVHD), Uveitis

# EPCLUSA

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## Products Affected

- EPCLUSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin.
<b>Required Medical Information</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	3 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance

# EPIDIOLEX

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## Products Affected

- EPIDIOLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies
<b>Age Restrictions</b>	Patients 1 year and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For Lennox-Gastaut syndrome, prior use of 2 of the following is required: clonazepam, felbamate, lamotrigine, topiramate, rufinamide (Banzel), clobazam. For Dravet syndrome, prior use of 2 of the following is required: Diacomit, clobazam and Fintepla. For tuberous sclerosis complex, prior use of everolimus (tablets for suspension) is required.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# EPOETIN ALFA

## Products Affected

- PROCRIT
- RETACRIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	CRF anemia in patients not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa, Mircera or Aranesp. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp.MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start.Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 mU/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - Hgb is less than or equal to 13, surgery is elective, nonvascular and non-cardiac and pt is unwilling or unable to donate autologous blood prior to surgery
<b>Age Restrictions</b>	MDS anemia = 18 years of age and older.
<b>Prescriber Restrictions</b>	MDS anemia, myelofibrosis-prescribed by or in consultation with, a hematologist or oncologist.
<b>Coverage Duration</b>	Chemo-6m,Transfus-1m, CKD(dialysis)-3yrs, Myelofibrosis-init-3 mo, cont-1 yr, all others-1 yr
<b>Other Criteria</b>	Myelofibrosis-Initial-patient has a Hb less than 10 or serum erythropoietin less than or equal to 500 Mu/mL. Cont-approve if according to the prescriber the patient has had a response to therapy. Anemia in patients with chronic renal failure on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundled payment benefit).
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Anemia due to myelodysplastic syndrome (MDS), myelofibrosis



# ESBRIET

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## Products Affected

- ESBRIET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# EXTAVIA

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## Products Affected

- EXTAVIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS) diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# EYLEA

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## Products Affected

- EYLEA

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

# FINTEPLA

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## Products Affected

- FINTEPLA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of diagnosis.
<b>Age Restrictions</b>	2 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist (initial therapy)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Dravet Syndrome-Initial therapy-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs or patient has tried or is concomitantly receiving Epidiolex, clobazam or Diacomit. Dravet Syndrome-Continuation-approve if the patient is responding to therapy. Lennox-Gastaut Syndrome, initial-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs. Lennox-Gastaut Syndrome, continuation-approve if the patient is responding to therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# FIRDAPSE

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## Products Affected

- FIRDAPSE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	History of seizures (initial therapy)
<b>Required Medical Information</b>	Diagnosis, seizure history, lab and test results
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or a neuromuscular specialist (initial therapy)
<b>Coverage Duration</b>	Initial-3 months, Cont-1 year
<b>Other Criteria</b>	Initial therapy-Diagnosis confirmed by at least one electrodiagnostic study (e.g., repetitive nerve stimulation) OR anti-P/Q-type voltage-gated calcium channels (VGCC) antibody testing according to the prescribing physician. Continuation-patient continues to derive benefit (e.g., improved muscle strength, improvements in mobility) from Firdapse, according to the prescribing physician.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# FORTEO

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## Products Affected

- FORTEO SUBCUTANEOUS PEN  
INJECTOR 20 MCG/DOSE  
(600MCG/2.4ML)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Auth will be for 2 years of total therapy between Tymlos/Bonsity/teriparatide over pt's lifetime
<b>Other Criteria</b>	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogonadal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast),

<b>PA Criteria</b>	<b>Criteria Details</b>
	OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# GATTEX

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## Products Affected

- GATTEX 30-VIAL
- GATTEX ONE-VIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	1 year and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist (initial and continuation)
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial-approve if the patient is currently receiving parenteral nutrition on 3 or more days per week or according to the prescriber, the patient is unable to receive adequate total parenteral nutrition required for caloric needs. Continuation-approve if the patient has experienced at least a 20 percent decrease from baseline in the weekly volume of parenteral nutrition.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# GILENYA

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## Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING

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## Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)
- *leuprolide subcutaneous kit*
- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)
- LUPRON DEPOT-PED
- LUPRON DEPOT-PED (3 MONTH)
- TRIPTODUR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For the treatment of cancer diagnosis must be prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	For abnormal uterine bleeding,uterine leiomyomata 6 mo.All other=12 mo
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Ovarian cancer, breast cancer, prophylaxis or treatment of uterine bleeding in patients with hematologic malignancy or undergoing cancer treatment or prior to bone marrow/stem cell transplantation, head and neck cancer-salivary gland tumors

# GROWTH HORMONES - GENOTROPIN

## Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	GHD in Children/Adolescents. Pt meets one of the following-1-had 2 GH stim tests with the following-levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon and both are inadequate as defined by a peak GH response which is below the normal reference range of the testing laboratory OR had at least 1 GH test and results show inadequate response and has at least one risk factor for GHD (e.g., ht for age curve deviated down across 2 major height percentiles [e.g., from above the 25 percentile to below the 10 percentile], growth rate is less than the expected normal growth rate based on age and gender, low IGF-1 and/or IGFBP-3 levels). 2.brain radiation or tumor resection and pt has 1 GH stim test and results is inadequate response or has def in at least 1 other pituitary hormone (that is, ACTH, TSH, gonadotropin deficiency [LH and/or FSH] are counted as 1 def], or prolactin).3. congenital hypopituitarism and has one GH stim test with inadequate response OR def in at least one other pituitary hormone and/or the patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk 4.pt has panhypopituitarism and has pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior pituitary bright spot on MRI or CT or pt has 3 or more pituitary hormone deficiencies or pt has had one GH test and results were inadequate 5.pt had a hypophysectomy. Cont-pt responding to therapy
<b>Age Restrictions</b>	ISS 5 y/o or older, SGA 2 y/o or older, SBS 18 y/o or older
<b>Prescriber Restrictions</b>	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.
<b>Coverage Duration</b>	ISS - 6 mos intial, 12 months cont tx, SBS-1 month, others 12 mos
<b>Other Criteria</b>	GHD initial in adults and adolescents 1. endocrine must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalamic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. has known mutations, embryonic lesions, congenital or genetic defects or structural hypothalamic pituitary defects, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L (BMI is less than or equal to 25), less than or equal to 3 and BMI is greater than or equal to 25 and less than or equal to 30 with a high pretest probability of GH deficiency, less than or equal to 1 and BMI is greater than or equal to 25 and less than or equal to 30 with a low pretest probability of GH deficiency or less than or equal to 1 mcg/L (BMI is greater than 30), if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, or Macrilen peak less than 2.8 ng/ml AND BMI is less than or equal to 40 AND if a transitional adolescent must be off tx for at least one month before retesting. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts greater than or equal to 5 or b. growth velocity is less than 10th percentile for age/gender. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. SHOX initial - SHOX def by chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial - baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). SBS initial pt receiving specialized nutritional support. Continuation of tx- approve if the patient has experienced improvement, according to the prescribing physician.</p>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	SHOX, SBS, CKD

# HAEGARDA

## Products Affected

- HAEGARDA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Prophylaxis-approve Haegarda if the patient meets one of the following criteria (A or B): A) Initial therapy-Approve if the patient meets both of the following criteria: Patient has HAE type I or type II as confirmed by the following diagnostic criteria (a and b): a) Patient has low levels of functional C1-INH protein (less than 50% of normal) at baseline, as defined by the laboratory reference values AND b) Patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values B) Patient is currently receiving Haegarda prophylaxis-Approve if the patient meets all of the following criteria (i and ii): i. patient has a diagnosis of HAE type I or II AND ii. According to the prescriber, the patient has had a favorable clinical response since initiating Haegarda prophylactic therapy compared with baseline (i.e., prior to initiating prophylactic therapy).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# HARVONI

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## Products Affected

- HARVONI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	3 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance

# HETLIOZ

## Products Affected

- HETLIOZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-24-patient is totally blind with no perception of light
<b>Age Restrictions</b>	Non-24-18 years or older (initial and continuation), SMS-16 years and older
<b>Prescriber Restrictions</b>	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders
<b>Coverage Duration</b>	6 mos initial, 12 mos cont
<b>Other Criteria</b>	Initial - dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy plus evaluation of sleep logs. Cont - Approve if pt has achieved adequate results with HetlioZ therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep). Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)-approve.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# HIGH RISK MEDICATIONS - BENZTROPINE

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## Products Affected

- *benztropine oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For all medically-accepted indications, approve if the prescriber confirms he/she has assessed risk versus benefit in prescribing benztropine for the patient and he/she would still like to initiate/continue therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# HIGH RISK MEDICATIONS - CARISOPRODOL

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## Products Affected

- *carisoprodol*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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 anticholinergic medications, the physician has assessed the risk.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HIGH RISK MEDICATIONS - CYCLOBENZAPRINE

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## Products Affected

- *cyclobenzaprine oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	The physician has assessed risk versus benefit in using this High Risk Medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

## Products Affected

- *promethazine oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For promethazine, authorize use without a previous drug trial for all FDA-approved indications other than emesis, including cancer/chemo-related emesis. For hydroxyzine hydrochloride, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. For the treatment of non-cancer/chemo related emesis, approve promethazine hydrochloride if the patient has tried a prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, aprepitant) for the current condition. Approve hydroxyzine hydrochloride if the patient has tried at least two other FDA-approved products for the management of anxiety. Prior to approval of promethazine and hydroxyzine, approve if the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HIGH RISK MEDICATIONS - PHENOBARBITAL

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## Products Affected

- *phenobarbital*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Coverage is not provided for use in sedation/insomnia.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For the treatment of seizures, approve only if the patient is currently taking phenobarbital.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - ANTIDEMENTIA AGENTS

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## Products Affected

- *ergoloid*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Safer alternatives are: donepezil, galantamine and rivastigmine.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - BUTALBITAL COMBINATIONS

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## Products Affected

- *ascomp with codeine*
- *butalbital-acetaminop-caf-cod*
- *butalbital-acetaminophen oral tablet 50-300 mg, 50-325 mg*
- *butalbital-acetaminophen-caff*
- *butalbital-aspirin-caffeine oral capsule*
- *tencon*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Safer alternatives are: naproxen sodium and ibuprofen.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - GLYBURIDE

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## Products Affected

- *glyburide*
- *glyburide micronized*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - GLYBURIDE/METFORMIN

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## Products Affected

- *glyburide-metformin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# HRM - SKELETAL MUSCLE RELAXANTS

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## Products Affected

- *carisoprodol-aspirin-codeine*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine oral tablet*
- *metaxalone*
- *methocarbamol oral*
- *orphenadrine citrate oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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 anticholinergic medications, the physician has assessed the risk.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HRM - TRIHEXYPHENIDYL

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## Products Affected

- *trihexyphenidyl*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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 anticholinergic medications, the physician has assessed the risk.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# HUMIRA

## Products Affected

- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried
<b>Age Restrictions</b>	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC), 18 or older (initial therapy only)
<b>Prescriber Restrictions</b>	Initial therapy only all dx-RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
<b>Coverage Duration</b>	initial 6 mo, cont tx 3 years.
<b>Other Criteria</b>	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial, patient has tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on Humira concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial, approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin,

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial, approve if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. UC initial, approve if the patient has had a trial of one systemic agent for UC. Uveitis initial, tried one of the following: periocular, intraocular, or systemic corticosteroid, immunosuppressives or other biologic therapy. HS initial, tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Continuation-approve if the patient has had a response as determined by the prescriber. Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ICATIBANT

## Products Affected

- *icatibant*
- *sajazir*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Treatment of Acute Attacks, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein (less than 50% of normal) at baseline, as defined by the laboratory reference values AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. Patients who have treated previous acute HAE attacks with icatibant-the patient has treated previous acute HAE type I or type II attacks with icatibant AND according to the prescribing physician, the patient has had a favorable clinical response (e.g., decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, decrease in HAE acute attack frequency or severity) with icatibant treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# INCRELEX

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## Products Affected

- INCRELEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Patients 2 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# INFLECTRA

## Products Affected

- INFLECTRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Biologic DMARD or Targeted Synthetic.
<b>Required Medical Information</b>	Diagnosis, concurrent medication, previous medications tried
<b>Age Restrictions</b>	CD and UC- Pts aged 6 years or more (initial therapy). PP-18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	All dx Initial therapy only -prescribed by or in consultation with: RA/AS/Still's disease/JIA/JRA-rheumatologist, PP/Pyoderma gangrenosum/Hidradenitis suppurativa-dermatologist, Psoriatic Arthritis-rheum or derm, CD/UC-gastroenterologist, Uveitis ophthalmologist, GVHD-a physician affiliated with a transplant center, oncologist, or hematologist, Behcet's Disease- rheum, derm, ophthalmologist, gastroenterologist, or neurologist, Sarcoidosis-pulmonol, ophthalmol, or derm
<b>Coverage Duration</b>	GVHD intl-1 mo, cont-3 mo.Pyoderma Gangrenosum-intl 4 mo, cont 1 yr.all others-intl 3 mo, cont-12 mo
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients already started on infliximab for a covered use, Behcet's disease, Still's disease, Uveitis, Pyoderma gangrenosum, Hidradenitis suppurativa,, Graft-versus-host disease, Juvenile Idiopathic Arthritis (JIA)/JRA, Sarcoidosis

# INFLIXIMAB

## Products Affected

- AVSOLA
- RENFLEXIS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Biologic DMARD or Targeted Synthetic.
<b>Required Medical Information</b>	Diagnosis, concurrent medication, previous medications tried
<b>Age Restrictions</b>	CD and UC- Pts aged 6 years or more (initial therapy). PP-18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	All dx Initial therapy only -prescribed by or in consultation with: RA/AS/Still's disease/JIA/JRA-rheumatologist, PP/Pyoderma gangrenosum/Hidradenitis suppurativa-dermatologist, Psoriatic Arthritis-rheum or derm, CD/UC-gastroenterologist, Uveitis ophthalmologist, GVHD-a physician affiliated with a transplant center, oncologist, or hematologist, Behcet's Disease- rheum, derm, ophthalmologist, gastroenterologist, or neurologist, Sarcoidosis-pulmonol, ophthalmol, or derm
<b>Coverage Duration</b>	GVHD intl-1 mo, cont-3 mo.Pyoderma Gangrenosum-intl 4 mo, cont 1 yr.all others-intl 6 mo, cont-12 mo
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients already started on infliximab for a covered use, Behcet's disease, Still's disease, Uveitis, Pyoderma gangrenosum, Hidradenitis suppurativa,, Graft-versus-host disease, Juvenile Idiopathic Arthritis (JIA)/JRA, Sarcoidosis



# INTRAROSA

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## Products Affected

- INTRAROSA

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

# KALYDECO

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## Products Affected

- KALYDECO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with Orkambi, Trikafta or Symdeko
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	4 months of age and older
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	CF - must have one mutation in the CFTR gene that is responsive to the requested medication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# KORLYM

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## Products Affected

- KORLYM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior surgeries
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
<b>Coverage Duration</b>	Endogenous Cushing's Syndrome-1 year. Pt awaiting surgery or response after radiotherapy-4 months
<b>Other Criteria</b>	Endogenous Cushing's Syndrome-Approve if, according to the prescribing physician, the patient is not a candidate for surgery or surgery has not been curative AND if Korlym is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Patients with Endogenous Cushing's Syndrome, awaiting surgery, Patients with Endogenous Cushing's syndrome, awaiting a response after radiotherapy

# KYNMOBI

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## Products Affected

- KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG

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

# LUMIZYME

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## Products Affected

- LUMIZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient acid alpha-glucosidase activity in blood, fibroblasts, or muscle tissue OR patient has a molecular genetic test demonstrating acid alpha-glucosidase gene mutation
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# MAVYRET

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## Products Affected

- MAVYRET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	3 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance

# MEGACE

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## Products Affected

- *megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml), 800 mg/20 ml (20 ml)*
- *megestrol oral tablet*

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

# METHAMPHETAMINE HCL

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## Products Affected

- *methamphetamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient must have failure, contraindication or intolerance to one formulary alternative such as dextroamphetamine, amphetamine/dextroamphetamine, methylphenidate or dexmethylphenidate before methamphetamine hcl is authorized.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# MODAFANIL

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## Products Affected

- *modafinil*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Excessive daytime sleepiness (EDS) associated with myotonic dystrophy. Adjunctive/augmentation for treatment of depression in adults.

# MOLECULAR TARGET INHIBITORS

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## Products Affected

- *abiraterone*
- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- ALECENSA
- ALUNBRIG
- AYVAKIT
- BALVERSA
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE
- CAPRELSA
- COMETRIQ
- COPIKTRA
- COTELLIC
- DAURISMO
- ERIVEDGE
- ERLEADA
- *erlotinib*
- *everolimus (antineoplastic)*
- EXKIVITY
- FARYDAK
- FOTIVDA
- GAVRETO
- GILOTRIF
- IBRANCE
- ICLUSIG
- IDHIFA
- *imatinib*
- IMBRUVICA
- INLYTA
- INQOVI
- INREBIC
- IRESSA
- JAKAFI
- KISQALI
- KISQALI FEMARA CO-PACK
- *lapatinib*
- LENVIMA
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA
- MEKINIST
- MEKTOVI
- NERLYNX
- NEXAVAR
- NINLARO
- NUBEQA
- ODOMZO
- ONUREG
- ORGOVYX
- PEMAZYRE
- PIQRAY
- POMALYST
- QINLOCK
- RETEVMO
- RUBRACA
- RYDAPT
- SCEMBLIX
- SPRYCEL
- STIVARGA
- SUNITINIB
- SUTENT
- SYNRIPO
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA
- TASIGNA
- TAZVERIK
- TEPMETKO
- TIBSOVO
- TRUSELTIQ
- TUKYSA
- TYKERB
- UKONIQ
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VIZIMPRO
- VONJO
- VOTRIENT
- XALKORI

- XOSPATA
- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)
- XTANDI
- ZEJULA
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

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

# NAGLAZYME

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## Products Affected

- NAGLAZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient N-acetylgalactosamine 4-sulfatase (arylsulfatase B) activity in leukocytes or fibroblasts OR has a molecular genetic test demonstrating arylsulfatase B gene mutation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NATPARA

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## Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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 patient is responding to Natpara therapy, as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NAYZILAM

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## Products Affected

- NAYZILAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications used at the same time
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NEXLETOL

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## Products Affected

- NEXLETOL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Patient has tried and failed or has a contraindication to a maximally tolerated statin or the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of two statins and during both trials the skeletal-related symptoms resolved during discontinuation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NEXLIZET

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## Products Affected

- NEXLIZET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Patient has tried and failed or has a contraindication to a maximally tolerated statin or the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of two statins and during both trials the skeletal-related symptoms resolved during discontinuation.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# NMDA RECEPTOR ANTAGONIST

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## Products Affected

- *memantine*
- NAMZARIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# NORTHERA

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## Products Affected

- *droxidopa*
- NORTHERA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medication history
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NUCALA

## Products Affected

- NUCALA SUBCUTANEOUS AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with Xolair or another Anti-Interleukin (IL) Monoclonal Antibody.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Asthma-6 years of age and older. EGPA/Polyps-18 years of age and older. HES-12 years and older.
<b>Prescriber Restrictions</b>	Asthma-Prescribed by or in consultation with an allergist, immunologist, or pulmonologist. EGPA-prescribed by or in consultation with an allergist, immunologist, pulmonologist or rheumatologist. HES-prescribed by or in consultation with an allergist, immunologist, hematologist, pulmonologist or rheumatologist. Polyps-prescribed by or in consult with allergist, immunologist or Otolaryngologist.
<b>Coverage Duration</b>	Initial-Asthma/EGPA/polyps-6 months, HES-8 months. 12 months continuation.
<b>Other Criteria</b>	Asthma initial-must have blood eosinophil level of greater than or equal to 150 cells per microliter within the prev 6 wks(prior to treatment with any anti-interleukin (IL)-5 therapy) AND Pt has received at least 3 mo of combo tx with an inhaled corticosteroid AND at least 1 additional asthma controller/maintenance med AND pt's asthma cont to be uncontrolled, or was uncontrolled prior to starting any anti-IL tx as defined by 1 of the following-pt exp 2 or more asthma exacerbations requiring tx with systemic corticosteroids in the prev yr, pt experienced 1 or more asthma exacerbation requiring hospital or an ED visit in the prev yr, pt has a FEV1 less than 80 percent predicted, Pt has an FEV1/FVC less than 0.80, or Pt's asthma worsens upon taper of oral corticosteroid tx.NOTE:An exception to the requirement for trial of 1 additional asthma controller/maintenance medication can be made if the pt has already received anti-IL-5 tx used concomitantly with an ICS for at least 3 mo. Cont-pt has responded to Nucala tx as determined by the prescribing physician AND Pt continues to receive tx with an inhaled corticosteroid. EGPA initial-pt has/had a blood eosinophil level of greater than or equal to 150 cells per microliter within

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>the previous 6 wks or within 6 wks prior to tx with any anti-interleukin (IL)-5 therapy. Cont-pt has responded to Nucala tx as determined by the prescribing physician. HES initial-pt has had hypereosinophilic syndrome for greater than or equal to 6 mo AND has FIP1L1-PDGFRalpha-negative disease AND the pt does NOT have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome AND prior to initiating tx with any anti-interleukin-5 tx, pt has/had a blood eosinophil level of greater than or equal to 1,000 cells per microliter. Cont-approve if pt has received at least 8 mo of tx with Nucala (patients who have received less than 8 mo of tx or who are restarting tx should be reviewed under initial tx) and pt has responded to Nucala tx. Nasal polyps, initial-approve if pt meets ALL of the following criteria(A, B, C and D):A) pt has chronic rhinosinusitis with nasal polyposis as evidenced by direct exam, endoscopy, or sinus CT scan AND B)pt has experienced 2 or more of the following symptoms for at least 6 mo:nasal congestion/obstruction/discharge, and/or reduction/loss of smell AND C)pt meets BOTH of the following (a and b): a)Pt has received at least 8 weeks of tx with intranasal corticosteroid AND b)Pt will cont to receive tx with an intranasal corticosteroid concomitantly with Nucala AND D)pt meets 1 of the following (a, b or c): a)Pt has received at least 1 course of tx with a systemic corticosteroid for 5 days or more within the previous 2 yrs, OR b)Pt has a contraindication to systemic corticosteroid therapy, OR c)Pt has had prior surgery for nasal polyps. Cont-approve if pt has received at least 6 mo of tx, continues to receive tx with an intranasal corticosteroid and has responded to tx.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# NUEDEXTA

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## Products Affected

- NUEDEXTA

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

# NUPLAZID

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## Products Affected

- NUPLAZID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# OCALIVA

## Products Affected

- OCALIVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial therapy)
<b>Coverage Duration</b>	6 months initial, 1 year continuation
<b>Other Criteria</b>	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) or other PBC-specific auto-antibodies, including sp100 or gp210, if AMA is negative 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)).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# OCREVUS

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## Products Affected

- OCREVUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other Disease-Modifying Agents used for MS
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a physician who specializes in the treatment of MS and/or a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# OCTREOTIDE INJECTABLE

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## Products Affected

- *octreotide acetate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# OFEV

## Products Affected

- OFEV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	IPF-Prescribed by or in consultation with a pulmonologist. Interstitial lung disease associated with systemic sclerosis-prescribed by or in consultation with a pulmonologist or rheumatologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP. Interstitial lung disease associated with systemic sclerosis-approve if the FVC is greater than or equal to 40 percent of the predicted value and the diagnosis is confirmed by high-resolution computed tomography. Chronic fibrosing interstitial lung disease-approve if the forced vital capacity is greater than or equal to 45% of the predicted value AND according to the prescriber the patient has fibrosing lung disease impacting more than 10% of lung volume on high-resolution computed tomography AND according to the prescriber the patient has clinical signs of progression.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# OPSUMIT

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## Products Affected

- OPSUMIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PAH WHO group, right heart catheterization
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1 patients are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ORENCIA

## Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial therapy only-RA and JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist.
<b>Coverage Duration</b>	6 months initial, 3 years cont.
<b>Other Criteria</b>	RA, approve if the patient has tried one of the following: Enbrel, Humira, Rinvoq, Xeljanz. PsA, approve if the patient has tried one of the following: Enbrel, Humira, Rinvoq, Stelara, Skyrizi, Xeljanz. JIA/JRA, approve if the patient has tried one of the following: Enbrel, Humira or Xeljanz. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ORKAMBI

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## Products Affected

- ORKAMBI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Combination use with Kalydeco, Trikafta or Symdeko.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# OSPHENA

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## Products Affected

- OSPHENA

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

# OXERVATE

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## Products Affected

- OXERVATE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an ophthalmologist.
<b>Coverage Duration</b>	2 months
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# PEGASYS

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## Products Affected

- PEGASYS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous medications tried, liver disease compensation status, concomitant medications for HCV
<b>Age Restrictions</b>	HCV - patients 5 years of age or older, HBV - patients 3 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# PHENYL BUTYRATE

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## Products Affected

- *sodium phenylbutyrate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concomitant use of Ravicti and Buphenyl
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
<b>Coverage Duration</b>	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
<b>Other Criteria</b>	Urea cycle disorders-approve if genetic testing confirmed a mutation resulting in a urea cycle disorder or if the patient has hyperammonemia.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# PHEOCHROMOCYTOMA

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## Products Affected

- *metyrosine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior medication trials
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial and continuation therapy for Demser (metyrosine))
<b>Coverage Duration</b>	Authorization will be for 1 year
<b>Other Criteria</b>	If the requested drug is Demser (metyrosine) for initial 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). If the requested drug is Demser (metyrosine) for continuation therapy, approve if the patient is currently receiving Demser (metyrosine) or has received Demser (metyrosine) in the past.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

## Products Affected

- *alyq*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, right heart cath results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets and suspension require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# PROMACTA

## Products Affected

- PROMACTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy. MDS-platelet counts.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Thrombocytopenia due to chronic ITP or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist (initial therapy). Thrombocytopenia in pt with chronic Hep C, approve if prescribed by, or after consultation with, a gastroenterologist, hematologist, hepatologist, or a physician who specializes in infectious disease (initial therapy). MDS-presc or after consult with heme/onc (initial therapy).
<b>Coverage Duration</b>	Chronic ITP/MDS initial-3 mo, cont 1yr, AA-initial-4 mo, cont-1 yr, Thrombo/Hep C-1 yr
<b>Other Criteria</b>	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, initial-approve if the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters and the patient is at an increased risk for bleeding AND the patient has tried ONE other therapy or has undergone a splenectomy. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications. Treatment of thrombocytopenia in patients with Chronic Hepatitis C initial-approve if the patient will be receiving interferon-based therapy for chronic hepatitis C AND to allow for initiation of antiviral therapy if the patient has low platelet counts at baseline (eg, less than 75,000 microliters). Aplastic anemia initial - approve if the patient has low platelet counts at baseline/pretreatment (e.g., less than 30,000 microliters) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate mofetil, sirolimus) OR patient will be using Promacta in combination with standard immunosuppressive therapy. Cont-approve if the patient demonstrates a beneficial clinical response. MDS initial-approve if patient has low- to intermediate-risk MDS AND the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters

<b>PA Criteria</b>	<b>Criteria Details</b>
	and is at an increased risk for bleeding. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Thrombocytopenia in Myelodysplastic Syndrome (MDS)

# PYRIMETHAMINE

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## Products Affected

- *pyrimethamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Patient's immune status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis

# PYRUKYND

## Products Affected

- PYRUKYND

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older (initial and continuation)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist (initial and continuation)
<b>Coverage Duration</b>	Initial-6 months, continuation-1 year
<b>Other Criteria</b>	Hemolytic anemia due to pyruvate kinase deficiency: Initial therapy- Approve if the patient has the presence of at least two variant/mutant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene and at least one of the variant/mutant alleles was a missense variant AND the patient has a current hemoglobin level less than or equal to 10g/dL or patient is currently receiving red blood cell transfusions regularly, defined as at least six transfusion within the last year. Continuation of therapy- Approve if the patient has the presence of at least two variant/mutant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene and at least one of the variant/mutant alleles was a missense variant AND the patient has a current hemoglobin level less than or equal to 12 g/dL AND the patient has experienced a benefit from therapy, defined as increase in or maintenance of hemoglobin levels, or improvement in or maintenance of hemolysis laboratory parameters, OR decrease in or maintenance of transfusion requirements.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# QUININE SULFATE

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## Products Affected

- *quinine sulfate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Babesiosis, uncomplicated Plasmodium vivax malaria.



# REBIF

## Products Affected

- REBIF (WITH ALBUMIN)
- REBIF TITRATION PACK
- REBIF REBIDOSE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	For patients requesting Rebif, approve if the patient has tried two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera (dimethyl fumarate).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# REPATHA

## Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use of Juxtapid or Praluent.
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
<b>Age Restrictions</b>	ASCVD/Primary Hyperlipidemia - 18 yo and older, HoFH/HeFH - 10 yo and older.
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
<b>Coverage Duration</b>	Approve for 3 years for ASCVD/HeFH/HoFH/primary hyperlipidemia.
<b>Other Criteria</b>	Hyperlipidemia with HeFH - approve if: 1) diagnosis of HeFH AND 2) tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the symptoms resolved upon discontinuation. Hyperlipidemia with ASCVD -approve if: 1) has one of the following conditions: prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND 2) tried ONE high intensity statin (defined above) and LDL remains 70 mg/dL or higher unless pt is statin intolerant (defined above). HoFH - approve if: 1) has one of the following: a) genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR b) untreated LDL greater than 500 mg/dL (prior to treatment), OR c) treated LDL greater than or equal to 300 mg/dL (after treatment but prior to agents such as Repatha, Kynamro or Juxtapid), OR d) has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) tried ONE high intensity statin (defined above) for 8 weeks or longer and LDL remains 70 mg/dL or

<b>PA Criteria</b>	<b>Criteria Details</b>
	higher unless statin intolerant (defined above). Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if the patient has tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# REVLIMID

## Products Affected

- *lenalidomide*
- REVLIMID

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis and previous therapies or drug regimens tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	<p>Follicular lymphoma-approve if the patient is using Revlimid in combination with rituximab or has tried at least one prior therapy. MCL-approve. MZL-approve. Multiple myeloma-approve. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried at least one prior therapy. Myelofibrosis-approve if according to the prescriber the patient has anemia and the pt has serum erythropoietin levels greater than or equal to 500 mU/mL or if the patient has serum erythropoietin level less than 500 mU/mL and experienced no response or loss of response to erythropoietic stimulating agents. Peripheral T-Cell Lymphoma or T-Cell Leukemia/Lymphoma-approve if the pt has tried at least one other therapy or regimen. CNS cancers (primary)-approve if according to the prescriber the patient has relapsed or refractory disease. Hodgkin lymphoma, classical-approve if the patient has relapsed or refractory disease. Castleman's disease-approve if the patient has relapsed/refractory or progressive disease. AIDS Related Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and the patient has relapsed or refractory disease.</p>
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis, Castleman's Disease, Hodgkin lymphoma (Classical), Peripheral T-Cell Lymphoma, T-Cell Leukemia/Lymphoma, Central nervous system cancer (primary), Acquired immune deficiency syndrome (AIDS)-related Kaposi's sarcoma.

# RINVOQ

## Products Affected

- RINVOQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	Atopic Dermatitis - 12 years and older. All others - 18 years and older
<b>Prescriber Restrictions</b>	RA, Ankylosing spondylitis prescribed by or in consultation with a rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Atopic Dermatitis-Prescribed by or in consultation with an allergist, immunologist or dermatologist. UC prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	Authorization will be for 6 months initial, 3 years cont.
<b>Other Criteria</b>	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). Atopic Dermatitis-Initial-meets both a and b: 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. UC initial, approve if the patient has had a trial of one systemic agent for UC. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ROMIDEPSIN

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## Products Affected

- ROMIDEPSIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Documentation of diagnosis and past medication history.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Use of romidepsin is considered medically necessary for the treatment of cutaneous T-cell lymphoma in patients that have tried and failed at least 1 prior therapy. B vs D coverage determination.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# ROZLYTREK

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## Products Affected

- ROZLYTREK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	Solid Tumors-12 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Solid Tumors-Approve if the patient meets the following criteria (A, B, and C): A) The patient has locally advanced or metastatic solid tumor AND B) The patient's tumor has neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND C) The patient meets one of the following criteria (i or ii): i. The patient has progressed on prior therapies OR ii. There are no acceptable standard therapies and the medication is used as initial therapy. Non-Small Cell Lung Cancer-Approve if the patient has ROS1-positive metastatic disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# SANDOSTATIN

## Products Affected

- SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous treatments/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Acromegaly-prescribed by or in consultation with an endocrinologist. All neuroendocrine tumors-prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist. Pheochromocytoma/paraganglioma-prescribed by or in consultation with an endo/onc/neuro. Meningioma-prescribed by or in consultation with an oncologist, radiologist or neurosurgeon. Thymoma/Thymic carcinoma-prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if the patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory AND the patient meets i., ii., or iii: i. has had an inadequate response to surgery and/or radiotherapy or ii. is not an appropriate candidate for surgery and/or radiotherapy or iii. the patient is experiencing negative effects due to tumor size (e.g., optic nerve compression). Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas)-approve.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Pheochromocytoma/paraganglioma, Meningioma, Thyoma and thymic carcinoma

# SAPROPTERIN

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## Products Affected

- KUVAN
- *sapropterin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with Palynziq (continuation only)
<b>Required Medical Information</b>	Diagnosis, Phe concentration
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases (initial therapy)
<b>Coverage Duration</b>	Initial-12 weeks, Continuation-1 year
<b>Other Criteria</b>	Initial - approve. Continuation - approve if the patient has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescribing physician OR patient had a 20% or greater reduction in blood Phe concentration from baseline OR treatment with sapropterin has resulted in an increase in dietary phenylalanine tolerance.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SIGNIFOR

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## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older (initial therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist or a physician or specializes in the treatment of Cushing's syndrome (initial therapy)
<b>Coverage Duration</b>	Cushing's-Initial-4 mo, Cont therapy - 1 yr. Pt awaiting surgery/response after radiotherapy-4 mo
<b>Other Criteria</b>	Cushing's disease, initial therapy - approve if, according to the prescribing physician, the patient is not a candidate for surgery, or surgery has not been curative. Cushing's disease, continuation therapy - approve if the patient has already been started on Signifor/Signifor LAR and, according to the prescribing physician, the patient has had a response and continuation of therapy is needed to maintain response.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SIRTURO

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## Products Affected

- SIRTURO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patients weighing less than 15 kg
<b>Required Medical Information</b>	Diagnosis, concomitant therapy
<b>Age Restrictions</b>	Patients 5 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with an infectious diseases specialist
<b>Coverage Duration</b>	9 months
<b>Other Criteria</b>	Tuberculosis, Pulmonary Multidrug-resistant or extensively drug resistant-prescribed as part of a combination regimen with other anti-tuberculosis agents
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SKYRIZI

## Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML
- SKYRIZI SUBCUTANEOUS SYRINGE KIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, Previous medication use
<b>Age Restrictions</b>	18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	PP-Prescribed by or in consultation with a dermatologist (initial therapy). Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist.
<b>Coverage Duration</b>	6 mos initial, 3 years cont
<b>Other Criteria</b>	PP initial, approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PsA initial - axial disease (sacroiliitis), patient has tried one conventional synthetic DMARD or NSAID for at least 3 months, unless intolerant. (note: patients who have already had a 3-month trial of a biologic are not required to step back and try a conventional synthetic DMARD or NSAID). Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SOMATULINE

## Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous treatments/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Acromegaly-prescribed by or in consultation with an endocrinologist. Carcinoid syndrome-prescribed by or in consultation with an oncologist, endocrinologist or gastroenterologist. All neuroendocrine tumors-prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist. Pheochromocytoma/paraganglioma-prescribed by or in consultation with an endo/onc/neuro.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if the patient has a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory AND the patient meets i., ii., or iii: i. has had an inadequate response to surgery and/or radiotherapy or ii. is not an appropriate candidate for surgery and/or radiotherapy or iii. the patient is experiencing negative effects due to tumor size (e.g., optic nerve compression). Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptide-secreting tumors [VIPomas], insulinomas)-approve. Carcinoid Syndrome-approve.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Pheochromocytoma/paraganglioma

# SOMAVERT

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## Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapy, concomitant therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. patient has had an inadequate response to surgery and/or radiotherapy OR ii. The patient is NOT an appropriate candidate for surgery and/or radiotherapy OR iii. The patient is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# STELARA

## Products Affected

- STELARA SUBCUTANEOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	18 years and older CD/UC (initial therapy). PP-6 years and older (initial therapy).
<b>Prescriber Restrictions</b>	PP-Prescr/consult w/derm.PsA-prescr/consult w/rheum or derm.CD/UC-prescr/consult w/gastro.
<b>Coverage Duration</b>	PP/PsA Init-3mo,CD/UC load-approve 1 dose IV,CD/UC post IV load-SC 6 mo,cont tx-SC 3 yr
<b>Other Criteria</b>	PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). PP initial, approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial, approve if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. UC initial, approve if the patient has had a trial of one systemic agent for UC.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# SUCRAID

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## Products Affected

- SUCRAID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, genetic and lab test results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a geneticist, gastroenterologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of congenital diarrheal disorders
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Approve if the patient has a laboratory test demonstrating deficient sucrase or isomaltase activity in duodenal or jejunal biopsy specimens OR patient has a sucrose hydrogen breath test OR has a molecular genetic test demonstrating sucrose-isomaltase mutation in saliva or blood.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SYMDEKO

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## Products Affected

- SYMDEKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patients with unknown CFTR gene mutations, Combination therapy with Orkambi, Kalydeco or Trikafta
<b>Required Medical Information</b>	Diagnosis, specific CFTR gene mutations
<b>Age Restrictions</b>	Six years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - must be homozygous for the F508del mutation or have at least one mutation in the CFTR gene that is responsive to the requested medication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SYMLIN

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## Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# SYNAGIS

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## Products Affected

- SYNAGIS

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

# TAFAMIDIS

## Products Affected

- VYNDAMAX
- VYNDAQEL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with Onpattro or Tegsedi. Concurrent use of Vyndaqel and Vyndamax.
<b>Required Medical Information</b>	Diagnosis, genetic tests and lab results
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Cardiomyopathy of Wild-Type or Hereditary Transthyretin Amyloidosis- approve if the diagnosis was confirmed by one of the following (i, ii or iii): i. A technetium pyrophosphate scan (i.e., nuclear scintigraphy), ii. Amyloid deposits are identified on cardiac biopsy OR iii. patient had genetic testing which, according to the prescriber identified a TTR mutation AND Diagnostic cardiac imaging (e.g., echocardiogram, cardiac magnetic imaging) has demonstrated cardiac involvement (e.g., increased thickness of the ventricular wall or interventricular septum).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TALTZ

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## Products Affected

- TALTZ SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, Previous medication use
<b>Age Restrictions</b>	PP-6 years and older (initial therapy), all other dx-18 years of age and older (initial therapy)
<b>Prescriber Restrictions</b>	All dx initial therapy only-PP-Prescribed by or in consultation with a dermatologist. PsA prescribed by or in consultation with a rheumatologist or a dermatologist. AS-prescribed by or in consultation with a rheum.
<b>Coverage Duration</b>	Initial authorization will be for 6 months, 3 years continuation
<b>Other Criteria</b>	PP, approve if the patient has tried two of the following: Enbrel, Humira, Skyrizi, or Stelara. PsA, approve if the patient has tried two of the following: Enbrel, Humira, Rinvoq, Stelara, Skyrizi, Xeljanz. AS, approve if the patient has tried two of the following: Enbrel, Humira, Xeljanz. Non-radiographic axial spondylitis (nr-axSpA)-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroiliitis reported on MRI. Continuation-approve if the patient has had a response as determined by the prescriber.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TARGRETIN TOPICAL

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## Products Affected

- TARGRETIN TOPICAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapies tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TERIPARATIDE

## Products Affected

- TERIPARATIDE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Auth will be for 2 years of total therapy between Tymlos/teriparatide over pt's lifetime
<b>Other Criteria</b>	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.



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

# TETRABENAZINE

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## Products Affected

- *tetrabenazine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	Chorea associated with Huntington's Disease-approve if the diagnosis of Huntington's Disease is confirmed by genetic testing.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.

# THALOMID

## Products Affected

- THALOMID

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Erythem Nodosum Leprosum-approve. Multiple Myeloma-approve. Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried at least two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if according to the prescriber the patient has anemia and has serum erythropoietin levels greater than or equal to 500 mU/mL or if the patient has serum erythropoietin level less than 500 mU/mL and experienced no response or loss of response to erythropoietic stimulating agents. Prurigo nodularis, approve. Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried at least two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine). AIDS Related Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and has relapsed or refractory disease. Castleman's disease-approve if the patient has multicentric Castleman's disease, is negative for the human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8) and has hyaline vascular histology.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, AIDS related Kaposi's Sarcoma, Castleman's Disease.

# TOLVAPTAN

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## Products Affected

- SAMSCA ORAL TABLET 15 MG
- *tolvaptan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with Jynarque.
<b>Required Medical Information</b>	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 30 days
<b>Other Criteria</b>	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on tolvaptan/Samsca and has received less than 30 days of therapy.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TOPICAL AGENTS FOR ATOPIC DERMATITIS

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## Products Affected

- *pimecrolimus*
- *tacrolimus topical*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# TOPICAL RETINOID PRODUCTS

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## Products Affected

- AVITA
- *tretinoin microspheres*
- *tretinoin*

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

# TOPIRAMATE/ZONISAMIDE

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## Products Affected

- EPRONTIA
- *topiramate oral capsule, sprinkle*
- *topiramate oral tablet*
- TROKENDI XR
- *zonisamide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Coverage is not provided for weight loss or smoking cessation.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A



# TRANSMUCOSAL FENTANYL DRUGS

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## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TRELSTAR

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## Products Affected

- TRELSTAR INTRAMUSCULAR  
SUSPENSION FOR RECONSTITUTION

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

# TRIENTINE

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## Products Affected

- *trientine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, medication history, pregnancy status, disease manifestations
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For Wilson's Disease, approve if the patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant, OR 6) the patient has been started on therapy with trientine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TRIKAFTA

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## Products Affected

- TRIKAFTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Patients with unknown CFTR gene mutations. Combination therapy with Orkambi, Kalydeco or Symdeko.
<b>Required Medical Information</b>	Diagnosis, specific CFTR gene mutations, concurrent medications
<b>Age Restrictions</b>	Six years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - must have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive to the requested medication.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TURALIO

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## Products Affected

- TURALIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis)-approve if, according to the prescriber, the tumor is not amenable to improvement with surgery. Histiocytic Neoplasms-approve if the patient has a colony stimulating factor 1 receptor (CSF1R) mutation AND has one of the following conditions (i, ii, or iii): i. Langerhans cell histiocytosis OR ii. Erdheim-Chester disease OR iii. Rosai-Dorfman disease.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Histiocytic Neoplasms

# TYMLOS

## Products Affected

- TYMLOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, calcitonin nasal spray [Fortical], Forteo), Evenity except calcium and Vitamin D. Previous use of Tymlos and/or teriparatide for a combined total no greater than 2 years duration during a patient's lifetime.
<b>Required Medical Information</b>	Previous medications tried, renal function
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 2 yrs of total therapy between Tymlos/teriparatide over a pt's lifetime.
<b>Other Criteria</b>	Treatment of PMO, approve if the patient meets ONE of the following criteria: patient has tried one oral bisphosphonate or cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or patient cannot remain in an upright position post oral bisphosphonate administration or patient has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR patient has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR patient has severe renal impairment or CKD, OR patient has had an osteoporotic fracture or fragility fracture.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# TYSABRI

## Products Affected

- TYSABRI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use of other disease-modifying agents used for MS. Concurrent use with immunosuppressants (eg, 6-mercaptopurine, azathioprine, cyclosporine, methotrexate) in Crohn's disease (CD) patient
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 and older (initial and continuation)
<b>Prescriber Restrictions</b>	MS: prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of MS. (initial and continuation) CD: prescribed by, or in consultation with, a gastroenterologist (initial and continuation)
<b>Coverage Duration</b>	MS-Authorization will be for 1 year.CD, initial-3 mo. CD, cont therapy-1 year.
<b>Other Criteria</b>	Adults with a relapsing form of MS-initial. Patient has had an inadequate response to, or is unable to tolerate, one disease modifying agent used for MS: (eg, interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia), glatiramer acetate (Copaxone/Glatopa), Plegridy, fingolimod (Gilenya), Tecfidera, Lemtrada, daclizumab (Zinbryta), Aubagio, Mavenclad, Mayzent, Vumerity, Lemtrada, Ocrevus) OR the patient has highly active or aggressive disease according to the prescribing physician by meeting one of the following-the patient has demonstrated rapidly-advancing deterioration(s) in physical functioning (e.g., loss of mobility/or lower levels of ambulation, severe changes in strength or coordination OR disabling relapse(s) with suboptimal response to systemic corticosteroids OR magnetic resonance imaging (MRI) findings suggest highly-active or aggressive multiple sclerosis (e.g., new, enlarging, or a high burden of T2 lesions or gadolinium lesions) OR manifestation of multiple sclerosis-related cognitive impairment. Adults with CD, initial. Patient has moderately to severely active CD and patient has tried two biologics for CD. CD, continuation therapy. Patient has had a response to Tysabri, as determined by the prescribing physician.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	Patients already started on Tysabri for a Covered Use.



# UPTRAVI

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## Products Affected

- UPTRAVI ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Confirmation of right heart catheterization, medication history.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Patient new to Uptravi therapy must meet a) OR b): a) tried one or is currently taking one oral therapy for PAH 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).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# VALTOCO

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## Products Affected

- VALTOCO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, other medications used at the same time
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# VANCOMYCIN

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## Products Affected

- *vancomycin oral capsule*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	2 weeks
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# VENTAVIS

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## Products Affected

- VENTAVIS

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

# VERZENIO

## Products Affected

- VERZENIO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For use with an aromatase inhibitor in postmenopausal women or men as initial endocrine-based therapy, approve if the patient has tried Ibrance OR Kisqali. For use with fulvestrant in patients with disease progression following endocrine therapy, approve if the patient has tried Ibrance OR Kisqali. For use in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for the adjuvant treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence and a Ki-67 score greater than or equal to 20% no trial of Ibrance or Kisqali is required. For use as monotherapy of advanced or metastatic disease following endocrine therapy and chemotherapy in the setting of metastatic disease, no trial of Ibrance or Kisqali is required.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# VIBERZI

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## Products Affected

- VIBERZI

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

# VITRAKVI

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## Products Affected

- VITRAKVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, NTRK gene fusion status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Solid tumors - approve if the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity AND there are no satisfactory alternative treatments or the patient has disease progression following treatment.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# VOSEVI

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## Products Affected

- VOSEVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Indications</b>	All FDA-approved Indications, Some Medically-accepted Indications.
<b>Off-Label Uses</b>	Indications consistent with current AASLD/IDSA guidance



# VUMERITY

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## Products Affected

- VUMERITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Information</b>	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# WELIREG

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## Products Affected

- WELIREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Van Hippel-Lindau Disease-approve if the patient meets the following (A, B, and C): A) Patient has a von Hippel-Lindau (VHL) germline alteration as detected by genetic testing, B) Does not require immediate surgery and C) Patient requires therapy for ONE of the following conditions (i, ii, iii, or iv): i. Central nervous system hemangioblastomas, OR ii. Pancreatic neuroendocrine tumors, OR iii. Renal cell carcinoma, OR iv. Retinal hemangioblastoma
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# XATMEP

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## Products Affected

- XATMEP

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

# XCOPRI

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## Products Affected

- XCOPRI 100MG X1), 350 MG/DAY (200 MG X1-
- XCOPRI MAINTENANCE PACK ORAL 150MG X1)
- TABLET 250MG/DAY(150 MG X1- • XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve if the patient has tried one other anticonvulsant therapy (eg, carbamazepine, divalproex sodium, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, topiramate, valproic acid).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

# XELJANZ

## Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, JIA/JRA, Ankylosing spondylitis, prescribed by or in consultation with a rheumatologist. PsA prescribed by or in consultation with a rheumatologist or a dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	PsA/RA/JIA/JRA/AS -6 months initial, UC-16 weeks initial, All diagnoses-3 years cont.
<b>Other Criteria</b>	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). UC initial, approve if the patient has had a trial of one systemic agent (e.g., 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone) NOTE: A trial of a biologic (e.g., Humira, an infliximab product) also counts as a trial of one systemic agent for UC. Juvenile Idiopathic Arthritis (JIA) [or Juvenile Rheumatoid Arthritis] (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthritis/active sacroiliac arthritis]-initial-approve Xeljanz if the patient meets ONE of the following: patient has tried one other medication for this condition (Note: Examples of other medications for JIA include methotrexate, sulfasalazine, or leflunomide, a nonsteroidal anti-inflammatory drug (NSAID). A previous trial of a biologic also counts as a trial of one medication.) OR Patient has aggressive disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# XENICAL

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## Products Affected

- XENICAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

# XGEVA

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## Products Affected

- XGEVA

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

# XIAFLEX

## Products Affected

- XIAFLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Retreatment (i.e., treatment beyond three injections per affected cord for those with Dupuytren's Contracture or beyond eight injections for Peyronie's Disease).
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Dupuytren's Contracture-administered by a healthcare provider experienced in injection procedures of the hand and in the treatment of Dupuytren's contracture. Peyronie's Disease -administered by a healthcare provider experienced in the treatment of male urological diseases.
<b>Coverage Duration</b>	Dupuytren's Contracture-3 months, Peyronie's Disease-6 months
<b>Other Criteria</b>	Dupuytren's Contracture-at baseline (prior to initial injection of Xiaflex), the patient had contracture of a metacarpophalangeal (MP) or proximal interphalangeal (PIP) joint of at least 20 degrees AND the patient will not be treated with more than a total of three injections (maximum) per affected cord. Peyronie's Disease-the patient meets ONE of the following (i or ii): i. at baseline (prior to use of Xiaflex), the patient has a penile curvature deformity of at least 30 degrees OR in a patient who has received prior treatment with Xiaflex, the patient has a penile curvature deformity of at least 15 degrees AND the patient has not previously been treated with a complete course (8 injections) of Xiaflex for Peyronie's disease.
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A



# XIFAXAN

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## Products Affected

- XIFAXAN

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

# XOLAIR

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody
<b>Required Medical Information</b>	Moderate to severe persistent asthma, baseline IgE level of at least 30 IU/mL. For asthma, patient has a baseline positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds).
<b>Age Restrictions</b>	Moderate to severe persistent asthma-6 years and older. CIU-12 years and older. Polyps-18 years and older
<b>Prescriber Restrictions</b>	Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist. Polyps-prescribed by or in consult with an allergist, immunologist, or otolaryngologist
<b>Coverage Duration</b>	asthma/CIU-Initial tx 4 months, Polyps-initial-6 months, continued tx 12 months
<b>Other Criteria</b>	Moderate to severe persistent asthma approve if pt meets criteria 1 and 2: 1) pt has received at least 3 months of combination therapy with an inhaled corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2)patients asthma is uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following (a, b, c, d, or e): a) The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b) The patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year OR c) Patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d) Patient has an FEV1/forced vital capacity (FVC) less than 0.80 OR e) The patients asthma worsens upon tapering of oral

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>corticosteroid therapy 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-4/13 therapy (Dupixent) used concomitantly with an ICS for at least 3 consecutive months. For continued Tx for asthma - patient has responded to therapy as determined by the prescribing physician and continues to receive therapy with one inhaled corticosteroid or inhaled corticosteroid containing combination product. For CIU cont tx - have responded to therapy as determined by the prescribing physician. Nasal Polyps Initial-Approve if the patient has a baseline IgE level greater than or equal to 30 IU/ml, patient is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell, patient is currently receiving therapy with an intranasal corticosteroid. Nasal polyps continuation-approve if the patient continues to receive therapy with an intranasal corticosteroid and has responded to therapy.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# XYREM

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## Products Affected

- XYREM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medication history
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by a sleep specialist physician or a Neurologist
<b>Coverage Duration</b>	12 months.
<b>Other Criteria</b>	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dexamethylphenidate, dextroamphetamine), modafinil, or armodafinil and narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Cataplexy treatment in patients with narcolepsy- approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

# ZYPREXA RELPREVV

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## Products Affected

- ZYPREXA RELPREVV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Dementia-related psychosis
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	N/A
<b>Indications</b>	All FDA-approved Indications.
<b>Off-Label Uses</b>	N/A

## PART B VERSUS PART D

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### Products Affected

- *acetylcysteine*
- *acyclovir sodium intravenous solution*
- *adriamycin intravenous recon soln 50 mg*
- *adrucil intravenous solution 2.5 gram/50 ml*
- *albuterol sulfate inhalation solution for nebulization*
- AMINOSYN II 15 %
- AMINOSYN-PF 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE)
- *amiodarone intravenous solution*
- *aprepitant*
- *arformoterol*
- ARRANON
- ARSENIC TRIOXIDE INTRAVENOUS SOLUTION 1 MG/ML
- *arsenic trioxide intravenous solution 2 mg/ml*
- ARZERRA
- ATGAM
- *azacitidine*
- AZASAN
- *azathioprine*
- *azathioprine sodium*
- BELEODAQ
- BENDEKA
- BIVIGAM
- *bleomycin*
- BLINCYTO INTRAVENOUS KIT
- BROVANA
- *budesonide inhalation*
- BUSULFAN
- *carboplatin intravenous solution*
- *carmustine*
- *cisplatin intravenous solution*
- *cladribine*
- CLINIMIX 5%/D15W SULFITE FREE
- CLINIMIX 4.25%/D10W SULF FREE
- CLINIMIX 4.25%/D5W SULFIT FREE
- CLINIMIX 5% -D20W(SULFITE-FREE)
- CLINIMIX 6% -D5W (SULFITE-FREE)
- CLINIMIX 8% -D10W(SULFITE-FREE)
- CLINIMIX 8% -D14W(SULFITE-FREE)
- CLINIMIX E 4.25%/D10W SUL FREE
- CLINISOL SF 15 %
- *clofarabine*
- COSMEGEN
- *cromolyn inhalation*
- *cyclophosphamide intravenous recon soln*
- CYCLOPHOSPHAMIDE INTRAVENOUS SOLUTION
- *cyclophosphamide oral*
- *cyclosporine intravenous*
- *cyclosporine modified*
- *cyclosporine oral capsule*
- *cytarabine*
- *cytarabine (pf)*
- *dacarbazine*
- *dactinomycin*
- *daunorubicin intravenous solution*
- *decitabine*
- *docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)*
- *doxorubicin intravenous recon soln 50 mg*
- *doxorubicin intravenous solution*
- *doxorubicin, peg-liposomal*
- *dronabinol*
- EMEND ORAL SUSPENSION FOR RECONSTITUTION
- ENGERIX-B (PF)
- ENGERIX-B PEDIATRIC (PF)
- ENVARSUS XR
- *epirubicin intravenous solution*
- ERBITUX
- ETOPOPHOS
- *etoposide intravenous*
- *everolimus (immunosuppressive)*
- FIRMAGON KIT W DILUENT SYRINGE
- FLEBOGAMMA DIF
- *floxuridine*
- *fludarabine*
- *fluorouracil intravenous*

- FOLOTYN
- *formoterol fumarate*
- *fulvestrant*
- GAMMAGARD LIQUID
- GAMMAGARD S-D (IGA < 1 MCG/ML)
- GAMMAKED INJECTION SOLUTION  
1 GRAM/10 ML (10 %), 10 GRAM/100  
ML (10 %), 20 GRAM/200 ML (10 %), 5  
GRAM/50 ML (10 %)
- GAMMAPLEX (WITH SORBITOL)
- GAMUNEX-C
- *gemcitabine intravenous recon soln*
- *gemcitabine intravenous solution 1  
gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml  
(38 mg/ml), 200 mg/5.26 ml (38 mg/ml)*
- GEMCITABINE INTRAVENOUS  
SOLUTION 100 MG/ML
- *gengraf*
- *granisetron hcl oral*
- HIZENTRA
- *idarubicin*
- *ifosfamide*
- INFUGEM
- INFUMORPH P/F
- INTRALIPID INTRAVENOUS  
EMULSION 20 %, 30 %
- *ipratropium bromide inhalation*
- *ipratropium-albuterol*
- *irinotecan*
- IXEMPRA
- JEVTANA
- KABIVEN
- KYPROLIS
- *levalbuterol hcl*
- MARQIBO
- MEDROL ORAL TABLET 2 MG
- *melphalan*
- *melphalan hcl*
- *mesna*
- *methotrexate sodium (pf)*
- *methotrexate sodium injection*
- *methylprednisolone oral tablet*
- *mitomycin intravenous*
- *mitoxantrone*
- MOZOBIL
- *mycophenolate mofetil*
- *mycophenolate mofetil (hcl)*
- *mycophenolate sodium*
- *nelarabine*
- NIPENT
- *nitroglycerin intravenous*
- NULOJIX
- NUTRILIPID
- OCTAGAM
- ONCASPAR
- *ondansetron*
- *ondansetron hcl oral*
- *oxaliplatin*
- *paclitaxel*
- *pentamidine inhalation*
- PERFOROMIST
- PERIKABIVEN
- PLENAMINE
- PORTRAZZA
- *prednisolone sodium phosphate oral  
tablet, disintegrating*
- PREHEVBRIO (PF)
- PREMASOL 10 %
- PRIVIGEN
- PROCALAMINE 3%
- PROGRAF INTRAVENOUS
- PROGRAF ORAL GRANULES IN  
PACKET
- PROLEUKIN
- PROSOL 20 %
- PULMICORT
- PULMOZYME
- RECOMBIVAX HB (PF)
- RYLAZE
- SANDIMMUNE ORAL SOLUTION
- SIMULECT
- *sirolimus*
- *tacrolimus oral*
- TEMODAR INTRAVENOUS
- *temsirolimus*
- TICE BCG
- *tobramycin in 0.225 % nacl*
- *toposar*
- *topotecan intravenous recon soln*
- *topotecan intravenous solution 4 mg/4 ml  
(1 mg/ml)*
- TPN ELECTROLYTES

- TRAVASOL 10 %
- TREANDA
- TROPHAMINE 10 %
- TYVASO
- TYVASO INSTITUTIONAL START KIT
- TYVASO REFILL KIT
- TYVASO STARTER KIT
- *valrubicin*
- *vinblastine*
- *vincasar pfs*
- *vincristine*
- *vinorelbine*
- VYXEOS
- XOPENEX
- XOPENEX CONCENTRATE
- YUPELRI
- ZALTRAP
- ZANOSAR
- ZOLADEX
- *zoledronic acid intravenous solution*
- *zoledronic acid-mannitol-water*
- *zoledronic ac-mannitol-0.9nacl*
- ZORTRESS ORAL TABLET 1 MG

### **Details**

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



## Index

### A

- ABELCET..... 14
- abiraterone..... 98, 99
- ABRAXANE ..... 15, 16
- acetylcysteine..... 190
- ACTHAR..... 1
- ACTIMMUNE..... 2
- acyclovir sodium intravenous solution ... 190
- ADCETRIS..... 15, 16
- ADEMPAS ..... 3
- adriamycin intravenous recon soln 50 mg  
..... 190
- adrucil intravenous solution 2.5 gram/50 ml  
..... 190
- AFINITOR DISPERZ..... 98, 99
- AFINITOR ORAL TABLET 10 MG . 98, 99
- AIMOVIG AUTOINJECTOR..... 4
- AJOVY AUTOINJECTOR ..... 5
- AJOVY SYRINGE..... 5
- albuterol sulfate inhalation solution for  
nebulization..... 190
- ALDURAZYME..... 6
- ALECENSA..... 98, 99
- ALIMTA..... 15, 16
- ALIQOPA..... 15, 16
- alosetron..... 7
- ALUNBRIG..... 98, 99
- alyq..... 123
- AMBISOME..... 14
- ambrisentan..... 9
- amikacin injection solution 1,000 mg/4 ml,  
500 mg/2 ml ..... 11, 12
- AMINOSYN II 15 % ..... 190
- AMINOSYN-PF 10 % ..... 190
- AMINOSYN-PF 7 % (SULFITE-FREE) 190
- amiodarone intravenous solution ..... 190
- amphotericin b ..... 14
- amphotericin b liposome..... 14
- ampicillin sodium..... 11, 12
- ampicillin-sulbactam..... 11, 12
- aprepitant..... 190
- ARALAST NP ..... 8
- ARANESP (IN POLYSORBATE)  
INJECTION SOLUTION 100 MCG/ML,  
200 MCG/ML, 25 MCG/ML, 40  
MCG/ML, 60 MCG/ML..... 17
- ARANESP (IN POLYSORBATE)  
INJECTION SYRINGE..... 17
- ARCALYST ..... 18
- arformoterol ..... 190
- ARIKAYCE..... 19
- armodafinil..... 20
- ARRANON..... 190
- ARSENIC TRIOXIDE INTRAVENOUS  
SOLUTION 1 MG/ML..... 190
- arsenic trioxide intravenous solution 2  
mg/ml ..... 190
- ARZERRA..... 190
- ascomp with codeine..... 78
- ATGAM..... 190
- AUBAGIO ..... 22
- AUSTEDO..... 23
- AVITA ..... 159
- AVONEX INTRAMUSCULAR PEN  
INJECTOR KIT ..... 24
- AVONEX INTRAMUSCULAR SYRINGE  
..... 24
- AVONEX INTRAMUSCULAR SYRINGE  
KIT ..... 24
- AVSOLA ..... 88
- AYVAKIT ..... 98, 99
- azacitidine ..... 190
- AZASAN ..... 190
- azathioprine..... 190
- azathioprine sodium..... 190
- azithromycin intravenous..... 11, 12
- aztreonam ..... 11, 12
- ### B
- BALVERSA ..... 98, 99
- BAVENCIO..... 15, 16
- BELEODAQ..... 190
- BENDEKA ..... 190
- BENLYSTA..... 25
- benztropine oral ..... 72
- BESPONSA ..... 15, 16
- BESREMI..... 26
- BETASERON SUBCUTANEOUS KIT .. 27
- bexarotene..... 28

BICILLIN L-A..... 11, 12  
 BIVIGAM..... 190  
 BLENREP..... 15, 16  
 bleomycin..... 190  
 BLINCYTO INTRAVENOUS KIT ..... 190  
 BORTEZOMIB INTRAVENOUS ..... 15, 16  
 bosentan ..... 29  
 BOSULIF..... 98, 99  
 BOTOX..... 30, 31  
 BRAFTOVI ORAL CAPSULE 75 MG .. 98,  
 99  
 BROVANA..... 190  
 BRUKINSA ..... 98, 99  
 budesonide inhalation ..... 190  
 BUSULFAN ..... 190  
 butalbital-acetaminop-caf-cod ..... 78  
 butalbital-acetaminophen oral tablet 50-300  
 mg, 50-325 mg ..... 78  
 butalbital-acetaminophen-caff ..... 78  
 butalbital-aspirin-caffeine oral capsule..... 78  
**C**  
 CABOMETYX ..... 98, 99  
 CALQUENCE ..... 98, 99  
 CAPRELSA ..... 98, 99  
 CARBAGLU..... 32  
 carboplatin intravenous solution ..... 190  
 carglumic acid..... 32  
 carisoprodol..... 73  
 carisoprodol-aspirin-codeine..... 81  
 carmustine ..... 190  
 caspofungin ..... 13  
 CAYSTON..... 33  
 CEFEPIME INTRAVENOUS..... 11, 12  
 cefotaxime injection recon soln 2 gram ... 11,  
 12  
 CEFOTETAN IN DEXTROSE, ISO-OSM  
 ..... 11, 12  
 cefotetan injection..... 11, 12  
 cefoxitin ..... 11, 12  
 cefoxitin in dextrose, iso-osm ..... 11, 12  
 ceftazidime ..... 11, 12  
 CEFTAZIDIME IN D5W ..... 11, 12  
 cefuroxime sodium injection recon soln 750  
 mg ..... 11, 12  
 cefuroxime sodium intravenous ..... 11, 12

CERZYME INTRAVENOUS RECON  
 SOLN 400 UNIT..... 34  
 CHEMET ..... 35  
 chlorzoxazone oral tablet 500 mg ..... 81  
 CHORIONIC GONADOTROPIN,  
 HUMAN INTRAMUSCULAR ..... 36  
 CIALIS ORAL TABLET 2.5 MG, 5 MG. 37  
 ciprofloxacin in 5 % dextrose ..... 11, 12  
 cisplatin intravenous solution ..... 190  
 cladribine..... 190  
 CLINDAMYCIN IN 0.9 % SOD CHLOR  
 ..... 11, 12  
 clindamycin in 5 % dextrose..... 11, 12  
 clindamycin phosphate injection..... 11, 12  
 clindamycin phosphate intravenous solution  
 600 mg/4 ml ..... 11, 12  
 CLINIMIX 5%/D15W SULFITE FREE 190  
 CLINIMIX 4.25%/D10W SULF FREE . 190  
 CLINIMIX 4.25%/D5W SULFIT FREE 190  
 CLINIMIX 5%-D20W(SULFITE-FREE)  
 ..... 190  
 CLINIMIX 6%-D5W (SULFITE-FREE)190  
 CLINIMIX 8%-D10W(SULFITE-FREE)  
 ..... 190  
 CLINIMIX 8%-D14W(SULFITE-FREE)  
 ..... 190  
 CLINIMIX E 4.25%/D10W SUL FREE 190  
 CLINISOL SF 15 %..... 190  
 clobazam ..... 38  
 clofarabine..... 190  
 clomiphene citrate ..... 39  
 COLISTIN (COLISTIMETHATE NA) .. 11,  
 12  
 COMETRIQ..... 98, 99  
 COPAXONE SUBCUTANEOUS  
 SYRINGE ..... 40  
 COPIKTRA..... 98, 99  
 CORLANOR ORAL TABLET ..... 41  
 COSMEGEN..... 190  
 COTELLIC ..... 98, 99  
 CRINONE VAGINAL GEL 8 % ..... 42  
 cromolyn inhalation ..... 190  
 cyclobenzaprine oral tablet ..... 74, 81  
 cyclophosphamide intravenous recon soln  
 ..... 190

CYCLOPHOSPHAMIDE INTRAVENOUS SOLUTION.....	190
cyclophosphamide oral .....	190
cyclosporine intravenous .....	190
cyclosporine modified.....	190
cyclosporine oral capsule .....	190
CYRAMZA.....	15, 16
CYSTARAN.....	43
cytarabine .....	190
cytarabine (pf).....	190
<b>D</b>	
dacarbazine .....	190
dactinomycin.....	190
dalfampridine .....	44
DANYELZA.....	15, 16
DARZALEX.....	15, 16
DARZALEX FASPRO.....	15, 16
daunorubicin intravenous solution.....	190
DAURISMO .....	98, 99
decitabine .....	190
deferiprone .....	45
dimethyl fumarate .....	47
docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml).....	190
doxorubicin intravenous recon soln 50 mg .....	190
doxorubicin intravenous solution.....	190
doxorubicin, peg-liposomal .....	190
doxy-100 .....	11, 12
doxycycline hyclate intravenous.....	11, 12
dronabinol .....	190
droxidopa .....	106
DUAVEE .....	48
DUPIXENT PEN .....	49, 50
DUPIXENT SYRINGE .....	49, 50
<b>E</b>	
ELAPRASE .....	51
ELIGARD.....	66
ELIGARD (3 MONTH).....	66
ELIGARD (4 MONTH).....	66
ELIGARD (6 MONTH).....	66
ELZONRIS .....	15, 16

EMEND ORAL SUSPENSION FOR RECONSTITUTION .....	190
EMPLICITI.....	15, 16
ENBREL.....	52, 53
ENBREL MINI.....	52, 53
ENBREL SURECLICK.....	52, 53
ENGERIX-B (PF).....	190
ENGERIX-B PEDIATRIC (PF).....	190
ENHERTU .....	15, 16
ENVARBUS XR.....	190
EPCLUSA.....	54
EPIDIOLEX.....	55
epirubicin intravenous solution.....	190
EPRONTIA.....	160
ERBITUX .....	190
ergoloid .....	77
ERIVEDGE.....	98, 99
ERLEADA .....	98, 99
erlotinib .....	98, 99
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG.....	11, 12
ESBRIET .....	57
ETOPOPHOS .....	190
etoposide intravenous.....	190
everolimus (antineoplastic).....	98, 99
everolimus (immunosuppressive) .....	190
EVOMELA .....	15, 16
EXKIVITY .....	98, 99
EXTAVIA.....	58
EYLEA .....	59
<b>F</b>	
FANAPT .....	21
FARYDAK .....	98, 99
fentanyl citrate buccal lozenge on a handle .....	161
FERRIPROX.....	45
FERRIPROX (2 TIMES A DAY) .....	45
FINTEPLA.....	60
FIRDAPSE.....	61
FIRMAGON KIT W DILUENT SYRINGE .....	190
FLEBOGAMMA DIF.....	190
floxuridine.....	190
fluconazole in nacl (iso-osm).....	13
fludarabine .....	190
fluorouracil intravenous .....	190

FOLOTYN ..... 191  
 formoterol fumarate ..... 191  
 FORTEO SUBCUTANEOUS PEN  
   INJECTOR 20 MCG/DOSE  
   (600MCG/2.4ML)..... 62, 63  
 FOTIVDA ..... 98, 99  
 fulvestrant ..... 191  
**G**  
 GAMMAGARD LIQUID..... 191  
 GAMMAGARD S-D (IGA < 1 MCG/ML)  
   ..... 191  
 GAMMAKED INJECTION SOLUTION 1  
   GRAM/10 ML (10 %), 10 GRAM/100  
   ML (10 %), 20 GRAM/200 ML (10 %), 5  
   GRAM/50 ML (10 %) ..... 191  
 GAMMAPLEX (WITH SORBITOL) .... 191  
 GAMUNEX-C ..... 191  
 GATTEX 30-VIAL..... 64  
 GATTEX ONE-VIAL ..... 64  
 GAVRETO ..... 98, 99  
 GAZYVA..... 15, 16  
 gemcitabine intravenous recon soln..... 191  
 gemcitabine intravenous solution 1  
   gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml  
   (38 mg/ml), 200 mg/5.26 ml (38 mg/ml)  
   ..... 191  
 GEMCITABINE INTRAVENOUS  
   SOLUTION 100 MG/ML..... 191  
 gengraf ..... 191  
 GENOTROPIN ..... 67, 68  
 GENOTROPIN MINIQUICK ..... 67, 68  
 gentamicin in nacl (iso-osm) intravenous  
   piggyback 100 mg/100 ml, 60 mg/50 ml,  
   80 mg/100 ml, 80 mg/50 ml..... 11, 12  
 GENTAMICIN IN NAACL (ISO-OSM)  
   INTRAVENOUS PIGGYBACK 100  
   MG/50 ML, 120 MG/100 ML ..... 11, 12  
 gentamicin injection solution 40 mg/ml .. 11,  
   12  
 gentamicin sulfate (ped) (pf)..... 11, 12  
 GILENYA ORAL CAPSULE 0.5 MG.... 65  
 GILOTRIF ..... 98, 99  
 glyburide ..... 79  
 glyburide micronized ..... 79  
 glyburide-metformin ..... 80  
 granisetron hcl oral ..... 191

**H**  
 HAEGARDA ..... 69  
 HALAVEN ..... 15, 16  
 HARVONI ..... 70  
 HETLIOZ..... 71  
 HIZENTRA..... 191  
 HUMIRA PEN..... 83, 84  
 HUMIRA PEN CROHNS-UC-HS START  
   ..... 83, 84  
 HUMIRA PEN PSOR-UVEITS-ADOL HS  
   ..... 83, 84  
 HUMIRA SUBCUTANEOUS SYRINGE  
   KIT 40 MG/0.8 ML ..... 83, 84  
 HUMIRA(CF)..... 83, 84  
 HUMIRA(CF) PEDI CROHNS STARTER  
   ..... 83, 84  
 HUMIRA(CF) PEN ..... 83, 84  
 HUMIRA(CF) PEN CROHNS-UC-HS... 83,  
   84  
 HUMIRA(CF) PEN PEDIATRIC UC 83, 84  
 HUMIRA(CF) PEN PSOR-UV-ADOL HS  
   ..... 83, 84  
**I**  
 IBRANCE..... 98, 99  
 icanitab..... 85  
 ICLUSIG..... 98, 99  
 idarubicin ..... 191  
 IDHIFA ..... 98, 99  
 ifosfamide ..... 191  
 imatinib ..... 98, 99  
 IMBRUVICA..... 98, 99  
 IMFINZI ..... 15, 16  
 INCRELEX..... 86  
 INFLECTRA..... 87  
 INFUGEM ..... 191  
 INFUMORPH P/F ..... 191  
 INLYTA..... 98, 99  
 INQOVI ..... 98, 99  
 INREBIC..... 98, 99  
 INTRALIPID INTRAVENOUS  
   EMULSION 20 %, 30 % ..... 191  
 INTRAROSA..... 89  
 ipratropium bromide inhalation ..... 191  
 ipratropium-albuterol ..... 191  
 IRESSA..... 98, 99  
 irinotecan..... 191

IXEMPRA.....	191
<b>J</b>	
JAKAFI.....	98, 99
JEMPERLI.....	15, 16
JEVTANA.....	191
<b>K</b>	
KABIVEN.....	191
KADCYLA.....	15, 16
KALYDECO.....	90
KEYTRUDA.....	15, 16
KIMMTRAK.....	15, 16
KISQALI.....	98, 99
KISQALI FEMARA CO-PACK.....	98, 99
KORLYM.....	91
KUVAN.....	138
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG.....	92
KYPROLIS.....	191
<b>L</b>	
lapatinib.....	98, 99
lenalidomide.....	132, 133
LENVIMA.....	98, 99
leuprolide subcutaneous kit.....	66
levalbuterol hcl.....	191
levofloxacin in d5w.....	11, 12
levofloxacin intravenous.....	11, 12
LIBTAYO.....	15, 16
lincomycin.....	11, 12
linezolid in dextrose 5%.....	11, 12
linezolid-0.9% sodium chloride.....	11, 12
LONSURF.....	98, 99
LORBRENA.....	98, 99
LUMAKRAS.....	98, 99
LUMIZYME.....	93
LUMOXITI.....	15, 16
LUPRON DEPOT.....	66
LUPRON DEPOT (3 MONTH).....	66
LUPRON DEPOT (4 MONTH).....	66
LUPRON DEPOT (6 MONTH).....	66
LUPRON DEPOT-PED.....	66
LUPRON DEPOT-PED (3 MONTH).....	66
LYBALVI.....	21
LYNPARZA.....	98, 99
<b>M</b>	
MARGENZA.....	15, 16
MARQIBO.....	191

MAVYRET.....	94
MEDROL ORAL TABLET 2 MG.....	191
megestrol oral suspension 400 mg/10 ml (10 ml), 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml), 800 mg/20 ml (20 ml).....	95
megestrol oral tablet.....	95
MEKINIST.....	98, 99
MEKTOVI.....	98, 99
melphalan.....	191
melphalan hcl.....	191
memantine.....	105
mesna.....	191
metaxalone.....	81
methamphetamine.....	96
methocarbamol oral.....	81
methotrexate sodium (pf).....	191
methotrexate sodium injection.....	191
methylprednisolone oral tablet.....	191
metro i.v.....	11, 12
metronidazole in nacl (iso-os).....	11, 12
metyrosine.....	122
mitomycin intravenous.....	191
mitoxantrone.....	191
modafinil.....	97
MONJUVI.....	15, 16
MOXIFLOXACIN-SOD.ACE,SUL- WATER.....	11, 12
moxifloxacin-sod.chloride(iso).....	11, 12
MOZOBIL.....	191
mycophenolate mofetil.....	191
mycophenolate mofetil (hcl).....	191
mycophenolate sodium.....	191
MYLOTARG.....	15, 16
<b>N</b>	
nafcillin in dextrose iso-osm.....	11, 12
nafcillin injection.....	11, 12
nafcillin intravenous recon soln 2 gram... 12.....	11,
NAGLAZYME.....	100
NAMZARIC.....	105
NATPARA.....	101
NAYZILAM.....	102
nelarabine.....	191
NERLYNX.....	98, 99
NEXAVAR.....	98, 99
NEXLETOL.....	103

NEXLIZET .....	104	paliperidone.....	21
NINLARO.....	98, 99	PEGASYS.....	120
NIPENT .....	191	PEMAZYRE.....	98, 99
nitroglycerin intravenous .....	191	penicillin g potassium .....	11, 12
NORTHERA.....	106	pentamidine inhalation.....	191
NOVAREL .....	36	PERFOROMIST .....	191
NUBEQA.....	98, 99	PERIKABIVEN.....	191
NUCALA SUBCUTANEOUS AUTO- INJECTOR.....	107, 108	PERJETA.....	15, 16
NUCALA SUBCUTANEOUS SYRINGE .....	107, 108	pfizerpen-g.....	11, 12
NUDEXTA.....	109	phenobarbital.....	76
NULOJIX.....	191	PHESGO.....	15, 16
NUPLAZID.....	110	pimecrolimus.....	158
NUTRILIPID .....	191	PIQRAY.....	98, 99
NUZYRA INTRAVENOUS .....	11, 12	PLENAMINE .....	191
<b>O</b>		POLIVY .....	15, 16
OCALIVA.....	111	polymyxin b sulfate.....	11, 12
OCREVUS.....	112	POMALYST.....	98, 99
OCTAGAM .....	191	PORTRAZZA.....	191
octreotide acetate .....	113	POTELIGEO.....	15, 16
ODOMZO .....	98, 99	prednisolone sodium phosphate oral tablet, disintegrating.....	191
OFEV .....	114	PREGNYL.....	36
ONCASPAR.....	191	PREHEVBRIO (PF) .....	191
ondansetron.....	191	PREMASOL 10 % .....	191
ondansetron hcl oral.....	191	PRIVIGEN.....	191
ONIVYDE .....	15, 16	PROCALAMINE 3% .....	191
ONUREG.....	98, 99	PROCRT.....	56
OPDIVO .....	15, 16	PROGRAF INTRAVENOUS.....	191
OPDUALAG.....	15, 16	PROGRAF ORAL GRANULES IN PACKET.....	191
OPSUMIT .....	115	PROLASTIN-C.....	8
ORBACTIV .....	11, 12	PROLEUKIN.....	191
ORENCIA.....	116	PROMACTA .....	124, 125
ORENCIA CLICKJECT.....	116	promethazine oral.....	75
ORGOVYX.....	98, 99	PROSOL 20 % .....	191
ORKAMBI.....	117	PULMICORT .....	191
orphenadrine citrate oral .....	81	PULMOZYME .....	191
OSPHENA .....	118	pyrimethamine .....	126
oxacillin injection.....	11, 12	PYRUKYND .....	127
oxaliplatin .....	191	<b>Q</b>	
oxandrolone.....	10	QINLOCK.....	98, 99
OXERVATE.....	119	quinine sulfate.....	128
<b>P</b>		<b>R</b>	
paclitaxel.....	191	REBIF (WITH ALBUMIN) .....	129
paclitaxel protein-bound .....	15, 16	REBIF REBIDOSE.....	129
PADCEV.....	15, 16	REBIF TITRATION PACK .....	129

RECOMBIVAX HB (PF)..... 191  
 REGRANEX..... 46  
 RENFLEXIS..... 88  
 REPATHA PUSHTRONEX..... 130, 131  
 REPATHA SURECLICK..... 130, 131  
 REPATHA SYRINGE..... 130, 131  
 RETACRIT..... 56  
 RETEVMO..... 98, 99  
 REVLIMID..... 132, 133  
 RINVOQ..... 134  
 ROMIDEPSIN..... 135  
 ROZLYTREK..... 136  
 RUBRACA..... 98, 99  
 RUXIENCE..... 15, 16  
 RYBREVANT..... 15, 16  
 RYDAPT..... 98, 99  
 RYLAZE..... 191  
**S**  
 sajazir..... 85  
 SAMSCA ORAL TABLET 15 MG..... 157  
 SANDIMMUNE ORAL SOLUTION .... 191  
 SANDOSTATIN LAR DEPOT  
     INTRAMUSCULAR  
     SUSPENSION,EXTENDED REL  
     RECON..... 137  
 sapropterin..... 138  
 SARCLISA..... 15, 16  
 SCEMBLIX..... 98, 99  
 SIGNIFOR..... 139  
 sildenafil (pulm.hypertension) oral tablet 123  
 SIMULECT..... 191  
 sirolimus..... 191  
 SIRTURO..... 140  
 SIVEXTRO INTRAVENOUS..... 11, 12  
 SKYRIZI SUBCUTANEOUS PEN  
     INJECTOR..... 141  
 SKYRIZI SUBCUTANEOUS SYRINGE  
     150 MG/ML..... 141  
 SKYRIZI SUBCUTANEOUS SYRINGE  
     KIT..... 141  
 sodium phenylbutyrate..... 121  
 SOMATULINE DEPOT..... 142  
 SOMAVERT..... 143  
 SPRYCEL..... 98, 99  
 STELARA SUBCUTANEOUS..... 144  
 STIVARGA..... 98, 99

STREPTOMYCIN..... 11, 12  
 SUCRAID..... 145  
 sulfamethoxazole-trimethoprim intravenous  
     ..... 11, 12  
 SUNITINIB..... 98, 99  
 SUTENT..... 98, 99  
 SYMDEKO..... 146  
 SYMLINPEN 120..... 147  
 SYMLINPEN 60..... 147  
 SYMPAZAN..... 38  
 SYNAGIS..... 148  
 SYNERCID..... 11, 12  
 SYNRIBO..... 98, 99  
**T**  
 TABRECTA..... 98, 99  
 tacrolimus oral..... 191  
 tacrolimus topical..... 158  
 tadalafil (pulm. hypertension)..... 123  
 tadalafil oral tablet 2.5 mg, 5 mg..... 37  
 TAFINLAR..... 98, 99  
 TAGRISSO..... 98, 99  
 TALTZ SYRINGE..... 150  
 TALZENNA..... 98, 99  
 TARGRETIN TOPICAL..... 151  
 TASIGNA..... 98, 99  
 tazicef..... 11, 12  
 TAZVERIK..... 98, 99  
 TECENTRIQ..... 15, 16  
 TEFLARO..... 11, 12  
 TEMODAR INTRAVENOUS..... 191  
 temsirolimus..... 191  
 tencon..... 78  
 TEPMETKO..... 98, 99  
 TERIPARATIDE..... 152, 153  
 tetrabenazine..... 154  
 THALOMID..... 155, 156  
 thiotepa..... 15, 16  
 TIBSOVO..... 98, 99  
 TICE BCG..... 191  
 tigecycline..... 11, 12  
 TIVDAK..... 15, 16  
 tobramycin in 0.225 % nacl..... 191  
 tobramycin sulfate..... 11, 12  
 tolvaptan..... 157  
 topiramate oral capsule, sprinkle..... 160  
 topiramate oral tablet..... 160

toposar.....	191	vinblastine.....	192
topotecan intravenous recon soln.....	191	vincasar pfs.....	192
topotecan intravenous solution 4 mg/4 ml (1 mg/ml).....	191	vincristine.....	192
TPN ELECTROLYTES.....	191	vinorelbine.....	192
TRAVASOL 10 %.....	192	VITRAKVI.....	175
TRAZIMERA.....	15, 16	VIZIMPRO.....	98, 99
TREANDA.....	192	VONJO.....	98, 99
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION.....	162	voriconazole intravenous.....	13
tretinoin.....	159	VOSEVI.....	176
tretinoin microspheres.....	159	VOTRIENT.....	98, 99
trientine.....	163	VRAYLAR.....	21
trihexyphenidyl.....	82	VUMERITY.....	177
TRIKAFTA.....	164	VYNDAMAX.....	149
TRIPTODUR.....	66	VYNDAQEL.....	149
TRODELVY.....	15, 16	VYXEOS.....	192
TROKENDI XR.....	160	<b>W</b>	
TROPHAMINE 10 %.....	192	WELIREG.....	178
TRUSELTIQ.....	98, 99	<b>X</b>	
TUKYSA.....	98, 99	XALKORI.....	98, 99
TURALIO.....	165	XATMEP.....	179
TYKERB.....	98, 99	XCOPRI.....	180
TYMLOS.....	166	XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1- 100MG X1), 350 MG/DAY (200 MG X1- 150MG X1).....	180
TYSABRI.....	167, 168	XCOPRI TITRATION PACK.....	180
TYVASO.....	192	XELJANZ.....	181
TYVASO INSTITUTIONAL START KIT .....	192	XELJANZ XR.....	181
TYVASO REFILL KIT.....	192	XENICAL.....	182
TYVASO STARTER KIT.....	192	XGEVA.....	183
<b>U</b>		XIAFLEX.....	184
UKONIQ.....	98, 99	XIFAXAN.....	185
UNITUXIN.....	15, 16	XOLAIR.....	186, 187
UPTRA VI ORAL.....	169	XOPENEX.....	192
<b>V</b>		XOPENEX CONCENTRATE.....	192
valrubicin.....	192	XOSPATA.....	99
VALTOCO.....	170	XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK).....	99
vancomycin oral capsule.....	171	XTANDI.....	99
VECTIBIX.....	15, 16	XYREM.....	188
VELCADE.....	15, 16		
VENCLEXTA.....	98, 99		
VENCLEXTA STARTING PACK....	98, 99		
VENTAVIS.....	172		
VERZENIO.....	173		
VIBERZI.....	174		



**Y**

YERVOY ..... 15, 16

YONDELIS..... 15, 16

YUPELRI..... 192

**Z**

ZALTRAP..... 192

ZANOSAR..... 192

ZEJULA ..... 99

ZELBORAF..... 99

ZEMAIRA ..... 8

ZEPZELCA..... 15, 16

ZIRABEV ..... 15, 16

ZOLADEX..... 192

zoledronic acid intravenous solution ..... 192

zoledronic acid-mannitol-water ..... 192

zoledronic ac-mannitol-0.9nacl..... 192

ZOLINZA ..... 99

zonisamide ..... 160

ZORTRESS ORAL TABLET 1 MG ..... 192

ZYDELIG ..... 99

ZYKADIA ORAL TABLET ..... 99

ZYNLONTA..... 15, 16

ZYPREXA RELPREVV ..... 189