Prior Authorization Criteria
2027 MCORE
Last Updated: 10/15/2026

ABRYSVO

Products Affected

- Abrysvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All indications: Vaccine is being used for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV). Immunization in age 60 years of age and older: Patient has not received an RSV vaccine (i.e., Abrysvo, Arexvy, MRESVIA) in their lifetime. Age greater than or equal to 60 years. Immunization in pregnancy: Patient has not received Abrysvo vaccine for the current pregnancy. Both of the following: 1) Will be used for active immunization of pregnant individuals at 32 through 36 weeks gestational age and 2) Will be used for the prevention of severe LRTD caused by RSV in infants from birth through 6 months of age. Immunization in age 18 through 59 years: Patient has not received an RSV vaccine (i.e., Abrysvo, Arexvy, MRESVIA) in their lifetime. Age 18 through 59 years. Patient is at increased risk for LRTD caused by RSV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ACITRETIN

Products Affected

- Acitretin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of severe psoriasis. Trial, contraindication, or intolerance to methotrexate or cyclosporine.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: Plan Year.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ACTIMMUNE

Products Affected

- Actimmune INJ 100MCG/0.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: a) Chronic granulomatous disease (CGD), or b) Severe, malignant osteopetrosis (SMO).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADALIMUMAB-AATY

Products Affected

- Adalimumab-aaty 1-pen Kit INJ 80MG/0.8ML
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ADALIMUMAB-ADBM

Products Affected

- Adalimumab-adbm

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thromboembolic pulmonary hypertension (CTEPH): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.
Age Restrictions	N/A
Prescriber Restrictions	PAH, CTEPH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, CTEPH: plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AKEEGA

Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is anaplastic lymphoma kinase (ALK)-positive. One of the following: 1) Disease is one of the following: a) Recurrent, b) Advanced, or c) Metastatic, or 2) Used as adjuvant treatment following tumor resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALOSETRON

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Irritable bowel syndrome (IBS) (Initial): Exclude if patient is of the male gender.
Required Medical Information	IBS (Initial): Diagnosis of chronic severe diarrhea-predominant IBS. Trial, contraindication, or intolerance to an anti-diarrheal agent [eg, loperamide].
Age Restrictions	IBS (Initial): 18 years and older.
Prescriber Restrictions	N/A
Coverage Duration	IBS (Initial): 12 weeks. IBS (Reauth): 6 months.
Other Criteria	IBS (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ALPHA - 1 PROTEINASE INHIBITORS

Products Affected

- Prolastin-c INJ 1000MG/20ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic, recurrent, or advanced NSCLC and tumor is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AMBRISENTAN

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

APREPITANT

Products Affected

- Aprepitant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Chemotherapy-induced Nausea and Vomiting (CINV): Patient is currently receiving moderately or highly emetogenic chemotherapy. Patient is concurrently on both corticosteroid [eg, Decadron (dexamethasone)] and 5-HT3 receptor antagonist [eg, Aloxi (palonosetron), Anzemet (dolasetron), Kytril (granisetron), Zofran (ondansetron)]. Delayed Chemotherapy-induced Nausea and Vomiting Prevention: Patient is currently receiving highly emetogenic chemotherapy and corticosteroid [eg, Decadron (dexamethasone)], or patient is receiving an anthracycline [eg, Adriamycin (doxorubicin), Ellence (epirubicin)] and Cytoxan (cyclophosphamide), or patient is currently receiving moderately emetogenic chemotherapy and was given aprepitant (oral or IV) on day 1 of chemotherapy. Postoperative Nausea and Vomiting (PONV): For the prevention of postoperative nausea and vomiting when administered prior to the induction of anesthesia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Acute CINV, Delayed CINV: plan year. PONV: 1 month
Other Criteria	Subject to Part B vs. Part D review.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARANESP

Products Affected

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

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cryopyrin-Associated Period Syndromes (CAPS): Diagnosis of CAPS, Familial Cold Autoinflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA. Patient weighs at least 10 kg. Patient is currently in remission (e.g., no fever, skin rash, and bone pain/no radiological evidence of active bone lesions/C-reactive protein [CRP] less than 5 mg/L). Recurrent Pericarditis (initial): Diagnosis of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart. Trial, contraindication, or intolerance to at least one of the following: nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen), colchicine, or corticosteroids (e.g., prednisone).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CAPS, DIRA: Plan Year. Recurrent Pericarditis (initial, reauth): Plan Year.
Other Criteria	Recurrent Pericarditis (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AREXVY

Products Affected

- Arexvy

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Mycobacterium avium complex (MAC) lung disease. Used as part of a combination antibacterial drug regimen. Used in patients who do not achieve at least two negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy (e.g., a macrolide, a rifamycin, ethambutol, etc).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist or pulmonologist.
Coverage Duration	Plan Year.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ATOVAQUONE SUSPENSION

Products Affected

- Atovaquone SUSP

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pneumocystis Jirovecii Pneumonia (PCP) Prophylaxis (initial): Used for prevention of PCP. Trial, contraindication, or intolerance to generic trimethoprim-sulfamethoxazole (TMP-SMX). Pneumocystis Jirovecii Pneumonia (PCP) Treatment: Diagnosis of mild to moderate PCP. Trial, contraindication, or intolerance to generic TMP-SMX. For continuation of therapy upon hospital discharge (patients who are transitioning from the hospital are allowed to continue use of the drug and other prior authorization requirements do not apply).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PCP Prophylaxis (initial, reauth): plan year. PCP Treatment: 21 days.
Other Criteria	PCP Prophylaxis (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AUGTYRO

Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) Advanced, b) Metastatic, or c) Recurrent. Disease is ROS1-positive. Solid Tumors: Diagnosis of solid tumors. Disease is positive for neutrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1). Disease is without a known acquired resistance mutation (e.g., TRKA G595R, G623R, G696A, F617L). Disease is one of the following: a) Locally advanced, b) Metastatic, or c) Unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: a) Disease has progressed following treatment, or b) There is no satisfactory alternative therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AUSTEDO

Products Affected

- Austedo
- Austedo Xr
- Austedo Xr Patient Titration Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tardive Dyskinesia: Diagnosis of tardive dyskinesia. One of the following: a) patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Chorea associated with Huntington's disease: Diagnosis of chorea in patients with Huntington's disease.
Age Restrictions	N/A
Prescriber Restrictions	Tardive Dyskinesia: Prescribed by or in consultation with a neurologist or psychiatrist. Chorea associated with Huntington's disease: Prescribed by or in consultation with a neurologist.
Coverage Duration	All Indications: Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AVMAPKI FAKZYNJA

Products Affected

- Avmapki Fakzynja Co-pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of recurrent low-grade serous ovarian cancer (LGSOC). Tumor is KRAS-mutated. Patient has received prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AVTOZMA SC

Products Affected

- Avtozma INJ 162MG/0.9ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Urothelial Carcinoma: Diagnosis of urothelial carcinoma (UC). One of the following: Locally advanced or metastatic. Presence of fibroblast growth factor receptor (FGFR) 3 genetic alterations. Disease has progressed on or after at least one line of prior systemic therapy (e.g., chemotherapy). One of the following: 1) Patient has received prior systemic therapy containing an immune checkpoint inhibitor (e.g., pembrolizumab, nivolumab, avelumab) or 2) Patient is not eligible for immune checkpoint inhibitor therapy (e.g., pembrolizumab, nivolumab, avelumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BENLYSTA

Products Affected

- Benlysta INJ 200MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic Lupus Erythematosus (SLE) (Initial): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine)]). Lupus Nephritis (Initial): Diagnosis of active lupus nephritis. Currently receiving standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	SLE, Lupus Nephritis (Initial, Reauth): 6 months.
Other Criteria	SLE, Lupus Nephritis (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BENZODIAZEPINES - ALPRAZOLAM

Products Affected

- Alprazolam TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for a medically accepted indication. Prescriber acknowledges safety concerns (e.g., drowsiness, increased risk of falls, altered mental status) with the use of the prescribed benzodiazepine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BENZODIAZEPINES - CLONAZEPAM

Products Affected

- Clonazepam TABS 0.5MG, 1MG, 2MG
- Clonazepam Odt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for a medically accepted indication. Prescriber acknowledges safety concerns (e.g., drowsiness, increased risk of falls, altered mental status) with the use of the prescribed benzodiazepine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BENZODIAZEPINES - CLORAZEPATE

Products Affected

- Clorazepate Dipotassium TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for a medically accepted indication. Prescriber acknowledges safety concerns (e.g., drowsiness, increased risk of falls, altered mental status) with the use of the prescribed benzodiazepine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BENZODIAZEPINES - DIAZEPAM

Products Affected

- Diazepam ORAL SOLN 5MG/5ML
- Diazepam TABS
- Diazepam Intensol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for a medically accepted indication. Prescriber acknowledges safety concerns (e.g., drowsiness, increased risk of falls, altered mental status) with the use of the prescribed benzodiazepine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BENZODIAZEPINES - LORAZEPAM

Products Affected

- Lorazepam TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for a medically accepted indication. Prescriber acknowledges safety concerns (e.g., drowsiness, increased risk of falls, altered mental status) with the use of the prescribed benzodiazepine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BENZODIAZEPINES - TEMAZEPAM

Products Affected

- Temazepam CAPS 15MG, 30MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for a medically accepted indication. Prescriber acknowledges safety concerns (e.g., drowsiness, increased risk of falls, altered mental status) with the use of the prescribed benzodiazepine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BESREMI

Products Affected

- Besremi
- Besremi Pen

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

BEXAROTENE

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of cutaneous T-cell lymphoma (CTCL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BOSENTAN

Products Affected

- Bosentan TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist
Coverage Duration	PAH: Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BOSULIF

Products Affected

- Bosulif CAPS
- Bosulif TABS 100MG, 500MG
- Bosutinib TABS 400MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous/myeloid leukemia (CML).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BRAFTOVI

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Patient is positive for BRAF V600 mutation. Used in combination with Mektovi (binimetinib). Colorectal Cancer: Diagnosis of colon cancer or rectal cancer. Disease is one of the following: advanced or metastatic. Patient is positive for BRAF V600E mutation. One of the following: 1) Patient has received prior therapy or 2) Used in combination with fluorouracil-based chemotherapy (e.g., mFOLFOX6, FOLFIRI). Used in combination with one of the following: 1) Erbitux (cetuximab) or 2) Vectibix (panitumumab). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: recurrent, advanced, or metastatic. Patient is positive for BRAF V600 mutation. Used in combination with Mektovi (binimetinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRIVIACT

Products Affected

- Brivaracetam ORAL SOLN
- Brivaracetam TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of partial-onset seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BRUKINSA

Products Affected

- Brukinsa TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Contraindication or intolerance to Calquence (acalabrutinib). Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL. Disease is relapsed, refractory, or progressive. Patient has received at least one anti-CD20-based regimen (e.g., rituximab, obinutuzumab). Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Contraindication or intolerance to Calquence (acalabrutinib). Follicular Lymphoma (FL): Diagnosis of FL. Disease is relapsed or refractory. Used in combination with Gazyva (obinutuzumab). Patient has received at least two prior lines of systemic therapy (e.g., CHOP: cyclophosphamide, doxorubicin, vincristine, and prednisone plus rituximab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BYLVAY

Products Affected

- Bylvay
- Bylvay (pellets)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Progressive familial intrahepatic cholestasis (PFIC) (initial): Diagnosis of progressive familial intrahepatic cholestasis (PFIC) type 1, 2, or 3, confirmed by one of the following: 1) Diagnostic test (e.g., liver function test, liver ultrasound and biopsy, bile analysis) or 2) Genetic testing. Alagille syndrome (ALGS) (initial): Diagnosis of Alagille Syndrome (ALGS). Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene.
Age Restrictions	PFIC (initial): Patient is 3 months of age or older
Prescriber Restrictions	PFIC, ALGS (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	PFIC, ALGS (initial): Plan Year. PFIC, ALGS (reauth): Plan year.
Other Criteria	PFIC, ALGS (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CABLIVI

Products Affected

- Cablivi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acquired thrombotic thrombocytopenic purpura (aTTP): Diagnosis of aTTP. First dose was/will be administered by a healthcare provider as a bolus intravenous injection. Used in combination with immunosuppressive therapy (e.g. rituximab, glucocorticoids [e.g., prednisone]). One of the following: 1) Used in combination with plasma exchange or 2) both of the following: patient has completed plasma exchange and less than 59 days have or will have elapsed beyond the last plasma exchange.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of one of the following: a) Advanced RCC, b) Relapsed RCC, or c) Hereditary leiomyomatosis and RCC (HLRCC). Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Used as subsequent-line systemic therapy. Differentiated Thyroid Cancer (DTC): Diagnosis of DTC. Disease is one of the following: a) locally advanced or b) metastatic. Disease has progressed following prior VEGFR-targeted therapy (e.g., Lenvima [lenvatinib], Nexavar [sorafenib]). Disease is radioactive iodine-refractory or ineligible. Pancreatic neuroendocrine tumors (pNET), Extra-pancreatic neuroendocrine tumors (epNET): Diagnosis of pNET or epNET. Disease is one of the following: a) unresectable, b) locally advanced, or c) metastatic. Tumors are well-differentiated.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CALQUENCE

Products Affected

- Calquence TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL). One of the following: 1) All of the following: a) Patient has received no prior therapy for MCL (e.g., bortezomib, rituximab), b) Patient is ineligible for autologous hematopoietic stem cell transplantation (HSCT), and c) Used in combination with bendamustine and rituximab, or 2) Patient has received at least one prior therapy for MCL (e.g., bortezomib, rituximab). Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CARGLUMIC ACID

Products Affected

- Carglumic Acid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency (AH due to NAGS): Diagnosis of acute hyperammonemia due to the deficiency of the hepatic enzyme NAGS. Medication will be used as adjunctive therapy to other ammonia lowering therapies (e.g., IV glucose, insulin, L-cartnitine). Chronic Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency (CH due to NAGS) (initial): Diagnosis of chronic hyperammonemia due to the deficiency of the hepatic enzyme NAGS. Medication will be used as maintenance therapy. Acute Hyperammonemia due to Propionic Acidemia (PA) or Methylmalonic Acidemia (MMA) (AH due to PA/MMA): Diagnosis of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA). Medication will be used as adjunctive therapy to other ammonia lowering therapies (e.g., IV glucose, insulin, L-carnitine).
Age Restrictions	N/A
Prescriber Restrictions	AH due to NAGS, CH due to NAGS (initial), AH due to PA/MMA: Prescribed by or in consultation with a specialist focused in the treatment of metabolic disorders
Coverage Duration	AH due to NAGS: 3 mo, CH due to NAGS (initial, reauth): Plan Year, AH due to PA/MMA: 1 mo.
Other Criteria	Chronic Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF): Diagnosis of CF and lung infection with positive culture demonstrating Pseudomonas aeruginosa infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): Diagnosis of a bile acid synthesis disorder due to a single enzyme defect. Peroxisomal disorders (PD) (initial): Diagnosis of a peroxisomal disorder, including Zellweger spectrum disorders. Patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), b) steatorrhea, or c) complications from decreased fat-soluble vitamin absorption (eg, poor growth). Will be used as an adjunctive treatment.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by a hepatologist, medical geneticist, gastroenterologist, or other specialist that treats inborn errors of metabolism.
Coverage Duration	All uses (initial): 3 months, (reauth): Plan year.
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CLOBAZAM

Products Affected

- Clobazam SUSP 2.5MG/ML
- Clobazam TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lennox-Gastaut syndrome: Diagnosis of Lennox-Gastaut syndrome. Used for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome. Dravet syndrome: Diagnosis of seizures associated with Dravet syndrome (DS). Used in combination with Diacomit.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CLONIDINE ER

Products Affected

- Clonidine Hydrochloride Er TB12

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of attention deficit hyperactivity disorder (ADHD).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COBENFY

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of schizophrenia. Trial, contraindication, or intolerance to one of the following: a) aripiprazole, b) asenapine, c) olanzapine, d) paliperidone, e) quetiapine (IR or ER), f) risperidone, or g) ziprasidone. Age under 65 years or both of the following: a) Age 65 years or older and b) Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Medullary Thyroid Cancer (MTC): Diagnosis of medullary thyroid cancer (MTC).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). Disease is relapsed or refractory. Trial, contraindication, or intolerance to at least two prior therapies for CLL/SLL [e.g., Leukeran (chlorambucil), Gazyva (obinutuzumab), Arzerra (ofatumumab), Bendeka (bendamustine), Imbruvica (ibrutinib), etc.].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CORLANOR

Products Affected

- Ivabradine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic heart failure (CHF) (initial): Diagnosis of CHF. Patient has NYHA Class II, III, or IV symptoms. Patient has a left ventricular ejection fraction less than or equal to 35%. Patient is in sinus rhythm. Patient has a resting heart rate of greater than or equal to 70 beats per minute. Trial, contraindication, or intolerance to two of the following at a maximally tolerated dose: A) One of the following: 1) ACE inhibitor (e.g., captopril, enalapril, lisinopril), 2) ARB (e.g., candesartan, losartan, valsartan), or 3) ARNI (e.g., Entresto [sacubitril and valsartan]), B) One of the following: 1) bisoprolol, 2) carvedilol, or 3) metoprolol succinate extended release, C) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)], or D) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone]. Dilated Cardiomyopathy (DCM) (initial): Diagnosis of heart failure due to DCM. Patient has NYHA Class II, III, or, IV symptoms. Patient is in sinus rhythm. Patient has an elevated heart rate. Trial, contraindication or intolerance to one of the following: 1) Beta blocker (e.g., bisoprolol, metoprolol succinate extended release), 2) Angiotensin-converting enzyme (ACE) inhibitor (e.g., captopril, enalapril), or 3) Diuretic Agent (e.g., spironolactone, furosemide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CHF, DCM (Initial, reauth): plan year
Other Criteria	CHF, DCM (reauth): Patient demonstrates positive clinical response to therapy.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COSENTYX

Products Affected

- Cosentyx INJ 150MG/ML, 75MG/0.5ML
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Disease is positive for BRAF V600E or V600K mutation. Used in combination with Zelboraf (vemurafenib). Histiocytic Neoplasm: Diagnosis of histiocytic neoplasm.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CRESEMBA ORAL

Products Affected

- Cresemba CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of invasive aspergillosis or invasive mucormycosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CRINONE

Products Affected

- Crinone GEL 8%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All indications: Excluded if for fertility uses.
Required Medical Information	Secondary amenorrhea: Diagnosis of secondary amenorrhea (the absence of menses in women who have already started menstruation who are not pregnant, breastfeeding, or in menopause).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CTEXLI

Products Affected

- Ctexli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of cerebrotendinous xanthomatosis (cholestanol storage disease). Disease is confirmed by the presence of pathogenic variant(s) in the CYP27A1 gene.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: a) Neurologist, b) Geneticist, c) Metabolic disease specialist, or d) endocrinologist.
Coverage Duration	Initial, Reauth: Plan year.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DANZITEN

Products Affected

- Danziten

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myeloid leukemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute myeloid leukemia (AML): Diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND Daurismo therapy to be given in combination with low-dose cytarabine AND One of the following: 1) Patient is greater than or equal to 75 years old, or 2) Patient has significant comorbidities that preclude the use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DEFERASIROX

Products Affected

- Deferasirox TABS
- Deferasirox TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Iron Overload due to Blood Transfusions (initial): Diagnosis of chronic iron overload (eg, sickle cell anemia, thalassemia, etc.) due to blood transfusion. Patient has blood transfusion of at least 100 mL/kg of packed red blood cells (eg, at least 20 units of packed red blood cells for a 40-kg person or more in individuals weighing more than 40 kg) prior to initiation of treatment with deferasirox. Patient has serum ferritin levels consistently greater than 1000 mcg/L prior to initiation of treatment with deferasirox. Chronic Overload in non-transfusion dependent thalassemia syndromes (initial): Diagnosis of chronic iron overload in non-transfusion dependent thalassemia syndrome. Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with deferasirox. Patient has serum ferritin levels consistently more than 300 mcg/L prior to initiation of treatment with deferasirox.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by a hematologist/oncologist or hepatologist.
Coverage Duration	Plan year
Other Criteria	Chronic Iron Overload due to Blood Transfusions, Chronic Overload in non-transfusion dependent thalassemia syndromes (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DEGARELIX

Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of seizures associated with Dravet Syndrome (DS). Used in combination with clobazam.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DICLOFENAC GEL 3%

Products Affected

- Diclofenac Sodium GEL 3%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Actinic Keratosis (initial): Diagnosis of Actinic Keratosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Actinic Keratosis (reauth): Patient demonstrates positive clinical response to therapy. At least 30 days have elapsed since cessation of diclofenac sodium 3% topical gel therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DICLOFENAC TOPICAL SOLUTION 1.5%

Products Affected

- Diclofenac Sodium TOPICAL SOLN 1.5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of osteoarthritis of the knee(s).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DOPTELET

Products Affected

- Doptelet

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DOPTELET SPRINKLE

Products Affected

- Doptelet Sprinkle

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

DRONABINOL

Products Affected

- Dronabinol CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial, contraindication, or intolerance (T/C/I) to a 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). T/C/I to one of the following: Ativan (lorazepam), Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Phenergan (promethazine), Reglan (metoclopramide), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 months. AIDS anorexia: Plan Year.
Other Criteria	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving cancer chemotherapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DROXIDOPA

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurogenic orthostatic hypotension (NOH): (Initial): Diagnosis of symptomatic NOH. NOH is caused by one of the following conditions: primary autonomic failure (eg, Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, non-diabetic autonomic neuropathy. Trial, contraindication, or intolerance to one of the following agents: Fludrocortisone acetate, midodrine.
Age Restrictions	N/A
Prescriber Restrictions	NOH (init): Prescribed by or in consultation with one of the following specialists: cardiologist, neurologist, nephrologist.
Coverage Duration	Initial: 1 month. Reauth: plan year
Other Criteria	(Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DUPIXENT

Products Affected

- Dupixent INJ 200MG/1.14ML, 300MG/2ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EBGLYSS

Products Affected

- Ebglyss

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ELIGARD

Products Affected

- Eligard

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Treatment of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EMFLAZA

Products Affected

- Deflazacort
- Jaythari
- Kymbee
- Pyquvi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EMGALITY

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Major Depressive Disorder (MDD). One of the following: 1) Trial, contraindication, or intolerance to TWO of the following: a) a serotonin and norepinephrine reuptake inhibitor (SNRI) (e.g., venlafaxine, desvenlafaxine, duloxetine), b) a selective serotonin reuptake inhibitor (SSRI) (e.g., fluoxetine, sertraline, paroxetine, escitalopram), c) mirtazapine, d) bupropion, OR 2) patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENBREL

Products Affected

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

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ENDARI

Products Affected

- L-glutamine PACK

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ENSACOVE

Products Affected

- Ensacove

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Tumor is anaplastic lymphoma kinase (ALK)-positive. Disease is one of the following: a) Advanced, b) Metastatic, or c) Recurrent. Patient has not previously received an ALK-inhibitor [e.g. Alecensa (alectinib), Alunbrig (brigatinib), Lorbrena (lorlatinib), Zykadia (ceritinib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ENTYVIO SC

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) (initial): Diagnosis of moderately to severely active CD. Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. CD, UC (initial): One of the following: a) Will be used as a maintenance dose following two doses of Entyvio IV for induction, or b) Patient is currently established on Entyvio IV.
Age Restrictions	N/A
Prescriber Restrictions	CD, UC (initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, UC (initial): 14 weeks. CD, UC (reauth): plan year.
Other Criteria	CD, UC (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EPCLUSA

Products Affected

- Sofosbuvir/velpatasvir

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lennox-Gastaut syndrome (LGS): Diagnosis of seizures associated with LGS. Trial of, contraindication, or intolerance to two formulary anticonvulsants (e.g., topiramate, lamotrigine, valproate). Dravet syndrome (DS): Diagnosis of seizures associated with DS. Tuberous sclerosis complex (TSC): Diagnosis of seizures associated with TSC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EPOETIN ALFA (PREFERRED)

Products Affected

- Procrit

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ERGOTAMINE - CAFFEINE TABLET

Products Affected

- Ergotamine Tartrate/caffeine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of vascular headache (e.g., migraine, migraine variants, or "histaminic cephalalgia"). Trial, contraindication, or intolerance to one formulary triptan (e.g., rizatriptan, sumatriptan). Not used concomitantly with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: Plan year.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Metastatic basal cell carcinoma (BCC): Diagnosis of metastatic basal cell carcinoma. Advanced basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma. One of the following: Cancer has recurred following surgery, Patient is not a candidate for surgery, or Patient is not a candidate for radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-metastatic castration-resistant prostate cancer (NM-CRPC): Diagnosis of non-metastatic, castration-resistant (chemical or surgical) or recurrent prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Zoladex [goserelin], Vantas [histrelin], Lupron [leuprolide], Trelstar [triptorelin], Firmagon [degarelix]) OR 2) Patient received a bilateral orchiectomy. Metastatic castration-sensitive prostate cancer (M-CSPC): Diagnosis of metastatic, castration-sensitive or naive prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Lupron[leuprolide], Trelstar[triptorelin], Zoladex [goserelin], Vantas [histrelin], Firmagon [degarelix]) OR 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ERLOTINIB

Products Affected

- Erlotinib Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) advanced, b) metastatic, or c) recurrent. Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletion mutations or exon 21 (L858R) substitution mutations or a known sensitizing EGFR mutation (e.g., in-frame exon 20 insertions, exon 18 G719 mutation, exon 21 L861Q mutation). Pancreatic Cancer: Diagnosis of locally advanced, unresectable or metastatic pancreatic cancer. Used in combination with Gemzar (gemcitabine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EVEROLIMUS

Products Affected

- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG
- Torpenz
- Yulithira

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuroendocrine Tumors (NET): One of the following: 1) Both of the following: a) Diagnosis (Dx) of neuroendocrine tumors of gastrointestinal origin, lung origin, or thymic origin, and b) Disease is unresectable, locally advanced, or metastatic, OR 2) Diagnosis of neuroendocrine tumors of pancreatic origin, OR 3) All of the following: a) Diagnosis of well-differentiated, grade 3 neuroendocrine tumor, b) Disease is unresectable, locally advanced, or metastatic, and c) Tumor has favorable biology (e.g., relatively low Ki-67 [less than 55%], slow growing, positive SSTR-based PET imaging). Renal Cell Carcinoma/Kidney Cancer: Dx of renal cell cancer/kidney cancer. Disease is one of the following: (1) relapsed or (2) stage IV disease. Renal angiomyolipoma with tuberous sclerosis complex (TSC): Dx of renal angiomyolipoma and TSC. Subependymal Giant Cell Astrocytoma (SEGA) with tuberous sclerosis (TS): Dx of SEGA associated with TS. Breast Cancer: Dx of recurrent or metastatic breast cancer. One of the following: 1) Disease is hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)] OR 2) Breast cancer is considered inflammatory. Disease is HER2-negative. One of the following: Patient is a postmenopausal woman, patient is a premenopausal woman being treated with ovarian ablation/suppression, or patient is male. One of the following: A) Both of the following: a) one of the following: 1) Disease progressed while on or within 12 months of non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)] therapy or 2) patient was treated with tamoxifen at any time AND b) Used in combination with Aromasin (exemestane) OR B) Used in combination with Fulvestrant or Tamoxifen.
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	All uses: Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EVEROLIMUS SOLUTION

Products Affected

- Everolimus TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuroendocrine Tumors (NET): One of the following: 1) Both of the following: a) Diagnosis (Dx) of neuroendocrine tumors of gastrointestinal origin, lung origin, or thymic origin, and b) Disease is unresectable, locally advanced, or metastatic, OR 2) Diagnosis of neuroendocrine tumors of pancreatic origin, OR 3) All of the following: a) Diagnosis of well-differentiated, grade 3 neuroendocrine tumor, b) Disease is unresectable, locally advanced, or metastatic, and c) Tumor has favorable biology (e.g., relatively low Ki-67 [less than 55%], slow growing, positive SSTR-based PET imaging). Renal Cell Carcinoma/Kidney Cancer: Dx of renal cell cancer/kidney cancer. Disease is one of the following: (1) relapsed or (2) stage IV disease. Renal angiomyolipoma with tuberous sclerosis complex (TSC): Dx of renal angiomyolipoma and TSC. Subependymal Giant Cell Astrocytoma (SEGA) with tuberous sclerosis (TS): Dx of SEGA associated with TS. Breast Cancer: Dx of recurrent or metastatic breast cancer. One of the following: 1) Disease is hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)] OR 2) Breast cancer is considered inflammatory. Disease is HER2-negative. One of the following: Patient is a postmenopausal woman, patient is a premenopausal woman being treated with ovarian ablation/suppression, or patient is male. One of the following: A) Both of the following: a) one of the following: 1) Disease progressed while on or within 12 months of non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)] therapy or 2) patient was treated with tamoxifen at any time AND b) Used in combination with Aromasin (exemestane) OR B) Used in combination with Fulvestrant or Tamoxifen.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Plan year
Other Criteria	TSC Associated Partial-Onset Seizures: Dx of TSC associated partial-onset seizures. Used as adjunctive therapy. All uses: Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FILSPARI (I)

Products Affected

- Filspari

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Diagnosis of seizures associated with Dravet syndrome, OR 2) Diagnosis of seizures associated with Lennox-Gastaut syndrome.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FLECTOR (I)

Products Affected

- Flector

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

FLUCYTOSINE

Products Affected

- Flucytosine CAPS 250MG, 500MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: a) candidal endocarditis, b) candidiasis, c) candidiasis of urogenital site, d) candida endophthalmitis, e) central nervous system candidiasis, f) cryptococcosis, g) cryptococcal meningitis - HIV infection, h) HIV infection - pulmonary cryptococcosis, i) peritoneal dialysis-associated peritonitis, Fungal. Used in combination with amphotericin B.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced renal cell carcinoma. Disease is one of the following: relapsed or refractory. Patient has received two or more prior systemic therapies (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FRUZAQLA

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of colorectal cancer. Disease is one of the following: Advanced or Metastatic. Patient has been previously treated with all of the following: A) Fluoropyrimidine-based chemotherapy (e.g., capecitabine, 5-FU), B) oxaliplatin-based chemotherapy (e.g., CAPEOX, FOLFOX), C) irinotecan-based chemotherapy (e.g., FOLFIRI, FOLFIRINOX), and D) Anti-VEGF biological therapy (e.g., aflibercept, bevacizumab, ramucirumab). One of the following: A) Patient has RAS mutant tumors, OR B) Both of the following: a) Patient has RAS wild type tumors, AND b) Patient has been previously treated with an anti-EGFR biological therapy (e.g., panitumumab, cetuximab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: recurrent, advanced, or metastatic. Presence of RET (rearranged during transfection) gene fusion-positive or RET rearrangement positive tumors. Thyroid Cancer: Diagnosis of thyroid cancer. Disease is one of the following: advanced or metastatic. Disease is rearranged during transfection (RET) gene fusion-positive. Disease requires treatment with systemic therapy. One of the following: patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC. One of the following: 1) Tumors have non-resistant epidermal growth factor (EGFR) mutations as detected by an FDA-approved test OR 2) squamous disease progressing after previous platinum-based chemotherapy (e.g., cisplatin, carboplatin) OR 3) tumors are positive for a known sensitizing EGFR mutation (e.g., in-frame exon 20 insertions, exon 18 G719 mutation, exon 21 L861Q mutation).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GOMEKLI

Products Affected

- Gomekli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of neurofibromatosis type 1. Patient has plexiform neurofibromas that are both of the following: symptomatic and not amenable to complete resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GROWTH HORMONES

Products Affected

- Genotropin
- Genotropin Miniquick

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

HERNEXEOS

Products Affected

- Hernexeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) unresectable, b) metastatic, c) recurrent, or d) advanced. Presence of HER2 (ERBB2) tyrosine kinase domain activating mutations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HYRNUO

Products Affected

- Hyrnuo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: advanced, metastatic, recurrent, or unresectable. Presence of HER2 (ERBB2) tyrosine kinase domain activating mutations. Patient has received prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IBRANCE

Products Affected

- Ibrance CAPS 125MG
- Ibrance TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IBTROZI

Products Affected

- Ibtrozi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: Advanced or Metastatic. Tumor is ROS1 positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ICATIBANT

Products Affected

- Icatibant Acetate

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous / Myeloid Leukemia (CML): Diagnosis of chronic myelogenous/myeloid leukemia (CML). One of the following: a) Both of the following: Disease is in the chronic phase AND resistance or intolerance to two or more alternative tyrosine kinase inhibitors (TKI) [eg, Bosulif (bosutinib), imatinib, Sprycel (dasatinib), Tasigna (nilotinib)], b) confirmed documentation of T315I mutation, or c) Both of the following: Disease is in the accelerated or blast phase AND no other kinase inhibitors are indicated. Acute Lymphoblastic Leukemia: Diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. AML is isocitrate dehydrogenase-2 (IDH2) mutation-positive. One of the following: A) Disease is relapsed or refractory, B) Patient is not a candidate for or patient declines intensive induction therapy, C) Used for post induction therapy following response to low intensity induction therapy, or D) Used for consolidation therapy as continuation of low-intensity regimen used for induction.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IMBRUVICA

Products Affected

- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 140MG, 280MG, 420MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Chronic Graft Versus Host Disease (cGVHD): Diagnosis of cGVHD AND trial of at least one other systemic therapy (e.g., corticosteroids like prednisone or methylprednisolone, mycophenolate, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IMKELDI

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of CML. Acute Lymphoblastic Leukemia (ALL): Diagnosis of Philadelphia chromosome positive/BCR ABL-positive (Ph+/BCR ABL+) ALL. Myelodysplastic/Myeloproliferative Disease (MDS/MPD): Diagnosis of MDS/MPD. One of the following: 1) Disease is associated with 5q32 translocations, 2) Disease is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements, or 3) disease is associated with a t(5:12) translocation associated with the ETV6-PDGFRbeta fusion gene. Aggressive Systemic Mastocytosis (ASM): Diagnosis of ASM. One of the following: a) Patient is without the D816V c-Kit mutation, b) c-Kit mutational status is unknown, c) Well-differentiated systemic mastocytosis (WDSM), or d) Eosinophilia is present with FIP1L1-PDGFRA fusion gene. Hypereosinophilic Syndrome (HES) and/or Chronic Eosinophilic Leukemia (CEL): Diagnosis of at least one of the following: HES or CEL. Dermatofibrosarcoma Protuberans (DFSP): Diagnosis of unresectable, recurrent, or metastatic DFSP. Gastrointestinal Stromal Tumors (GIST): Diagnosis of GIST.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INBRIJA

Products Affected

- Inbrija

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tardive Dyskinesia: Diagnosis of tardive dyskinesia. One of the following: a) patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Chorea associated with Huntington's disease: Diagnosis of chorea in patients with Huntington's disease.
Age Restrictions	N/A
Prescriber Restrictions	Tardive Dyskinesia: Prescribed by or in consultation with a neurologist or psychiatrist. Chorea associated with Huntington's disease: Prescribed by or in consultation with a neurologist.
Coverage Duration	All Indications: Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INLURIYO

Products Affected

- Inluriyo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Breast cancer is all of the following: a) Estrogen receptor-positive (ER+), b) Human epidermal growth factor receptor 2-negative (HER2-), and c) Estrogen receptor 1 (ESR1)-mutated. Disease is advanced or metastatic. Disease progression has occurred following at least one line of endocrine therapy (e.g., fulvestrant, anastrozole, letrozole, exemestane).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced Renal Cell Carcinoma: Diagnosis of renal cell cancer. One of the following: (1) diagnosis of stage IV disease, or (2) Both of the following: a) Disease is advanced, and b) One of the following: i) Patient has failed one prior systemic therapy (e.g., chemotherapy), or ii) Inlyta will be used in combination with Bavencio (avelumab) or Keytruda (pembrolizumab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: Both of the following: A) Diagnosis of one of the following: primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis, AND B) Disease is intermediate-2 or high-risk.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INSULIN - LIKE GROWTH FACTOR

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	IGF-1 deficiency (initial): Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). GH gene deletion (initial): Diagnosis of growth hormone gene deletion in patients who have developed neutralizing antibodies to GH.
Age Restrictions	N/A
Prescriber Restrictions	All uses (initial): Prescribed by or in consultation with an endocrinologist
Coverage Duration	All uses (initial, reauth): plan year
Other Criteria	All uses (reauth): Patient demonstrates positive clinical response to therapy. Both of the following: 1) Expected adult height is not obtained and 2) Documentation of expected adult height goal.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IRESSA

Products Affected

- Gefitinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) advanced, b) recurrent, or c) metastatic. One of the following: a) tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions, b) tumors are positive for EGFR exon 21 (L858R) substitution mutations, or c) tumors are positive for a known sensitizing EGFR mutation (e.g., S7671, L861Q, G719X).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ISOTRETINOIN

Products Affected

- Accutane CAPS 10MG, 20MG, 40MG
- Amnesteem
- Claravis
- Isotretinoin CAPS
- Zenatane

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy OR diagnosis of treatment resistant acne. Trial (at least 6 weeks), contraindication or intolerance to two of the following conventional therapy regimens: a) topical retinoid or retinoid-like agent [eg, Retin-A/Retin-A Micro (tretinoin)], b) oral antibiotic [eg, Ery-Tab (erythromycin), Minocin (minocycline)], c) topical antibiotic with or without benzoyl peroxide [eg, Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: Retreatment - 6 months
Other Criteria	Retreatment (Reauth): After greater than or equal to 2 months off therapy, persistent or recurring severe recalcitrant nodular acne is still present.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ITOVEBI

Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is one of the following: a) Locally advanced, or b) Metastatic. Disease is all of the following: a) PIK3CA-mutated, b) Hormone receptor (HR)-positive, and c) Human epidermal growth-factor receptor 2 (HER2)-negative. Used following recurrence on or after completing adjuvant endocrine therapy (e.g. Zoladex [goserelin], Arimidex [anastrozole], Nolvadex [tamoxifen]). Used in combination with both of the following: a) Ibrance (Palbociclib), and b) Fulvestrant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ITRACONAZOLE (CAPSULES)

Products Affected

- Itraconazole CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic Fungal Infections: Diagnosis of blastomycosis, histoplasmosis, or aspergillosis. Onychomycosis: Diagnosis of fingernail or toenail onychomycosis confirmed by one of the following: KOH test, fungal culture, or nail biopsy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Systemic Fungal infxns: plan year. Onychomycosis: (Fingernail) 2 mo. (Toenail) 3 mo.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IVERMECTIN TABLETS

Products Affected

- Ivermectin TABS 3MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Any medically accepted indication [e.g., Onchocerciasis due to nematode parasite, Pediculosis, Strongyloidiasis, Ascariasis, Scabies (including crusted scabies), Cutaneous larva migrans (hook worm disease), Enterobiasis, Filariasis, Trichuriasis, or Gnathostomiasis].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IVIG (PREFERRED)

Products Affected

- Gamunex-c INJ 1GM/10ML
- Octagam INJ 1GM/20ML, 2GM/20ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

IWILFIN

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of high-risk neuroblastoma (HRNB). Patient has shown at least a partial response to prior multiagent, multimodality therapy. Prior therapy included anti-GD2 immunotherapy (e.g., Danyelza [naxitamab-gqgk], Unituxin [dinutuximab]).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JAKAFI

Products Affected

- Jakafi
- Jakafi Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: Diagnosis of one of the following: Primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera. Trial, contraindication, or intolerance to one of the following: hydroxyurea or interferon therapy (e.g., Pegasys). Graft versus host disease (GVHD): One of the following: A) Diagnosis of acute GVHD AND Disease is steroid-refractory, or B) Diagnosis of Chronic GVHD AND Trial of at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JAYPIRCA

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Disease is one of the following: a) relapsed, or b) refractory. Patient has received at least two prior systemic therapies [e.g., chemotherapy] for MCL, one of which is a Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Calquence (acalabrutinib), Imbruvica (ibrutinib)]. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of one of the following: a) CLL, or b) SLL. Disease is one of the following: a) Relapsed, or b) Refractory. Patient has previously been treated with a covalent BTK inhibitor [e.g., Calquence (acalabrutinib), Imbruvica (ibrutinib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JIDEYTRO

Products Affected

- Jideytro

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

JYNARQUE

Products Affected

- Tolvaptan TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

KERENDIA (SGLT2)

Products Affected

- Kerendia

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

KISQALI

Products Affected

- Kisqali

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

KOMZIFTI

Products Affected

- Komzifti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Positive for nucleophosmin 1 (NPM1) mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KORLYM

Products Affected

- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Diagnosis of either type 2 diabetes mellitus or diagnosis of glucose intolerance. Patient has either failed surgery or patient is not a candidate for surgery. Patient is not pregnant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 6 months
Other Criteria	Reauth: Documentation of one of the following: patient has improved glucose tolerance while on therapy or patient has stable glucose tolerance while on therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KOSELUGO

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neurofibromatosis Type 1 (NF1): Diagnosis of NF1. Patient has plexiform neurofibromas that are both of the following: inoperable and causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment, bladder/bowel dysfunction).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KRAZATI

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Presence of KRAS G12C mutation. Disease is recurrent, advanced, or metastatic. Patient has received at least one prior systemic therapy (e.g., chemotherapy). Colorectal Cancer (CRC): Diagnosis of CRC. Presence of KRAS G12C mutation. Disease is recurrent, advanced, or metastatic. Patient has received at least one prior systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LAPATINIB

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	All of the following: A) Diagnosis of breast cancer, B) Disease is human epidermal growth factor receptor 2-positive (HER2+), AND C) One of the following: i) All of the following: a) Disease is recurrent unresectable (local or regional), or stage IV breast cancer, b) Disease is hormone receptor positive (HR+), and c) Used in combination with an aromatase inhibitor [eg, Aromasin (exemestane), Femara (letrozole), Arimedex (anastrozole)], OR ii) Both of the following: a) One of the following: i) Disease is recurrent unresectable (local or regional) or stage IV breast cancer, or ii) Breast cancer is unresponsive to preoperative systemic therapy (e.g., chemotherapy), and b) Used as fourth line therapy and beyond in combination with trastuzumab or Xeloda (capecitabine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LAZCLUZE

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: a) recurrent b) advanced c) metastatic. Disease is positive for one of the following: a) Epidermal growth factor receptor (EGFR) exon 19 deletion OR b) EGFR exon 21 L858R mutation. Used in combination with Rybrevant (amivantamab-vmjw).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LENALIDOMIDE

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Differentiated thyroid cancer (DTC): Diagnosis of DTC. Renal cell carcinoma: Diagnosis of Renal cell carcinoma. Hepatocellular Carcinoma (HCC): Diagnosis of Hepatocellular Carcinoma or liver cell carcinoma. Endometrial Carcinoma: Diagnosis of endometrial carcinoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LEQEMBI IQLIK

Products Affected

- Leqembi Iqlik

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LEUKINE (I)

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LEUPROLIDE ACETATE

Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Treatment of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate Cancer: plan year
Other Criteria	Prostate Cancer: Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIDOCAINE PATCH

Products Affected

- Lidocaine PTCH 5%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIFYORLI

Products Affected

- Lifyorli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Disease is platinum resistant. Used in combination with nab-paclitaxel. Patient has received one prior bevacizumab-containing systemic treatment regimen. Patient has not received more than three prior systemic treatment regimens.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LIVTENCITY

Products Affected

- Livtencity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cytomegalovirus (CMV) infection/disease. Patient is a recipient of one of the following: a) Hematopoietic stem cell transplant OR b) Solid organ transplant. Trial of a minimum 2 weeks duration, contraindication, or intolerance to one of the following therapies at an appropriately indicated dose: a) Intravenous (IV) ganciclovir, b) Oral valganciclovir, c) IV foscarnet, OR d) IV cidofovir. Patient weighs greater than or equal to 35 kg.
Age Restrictions	Patient is 12 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a provider who specializes in one of the following areas: transplant, oncology, or infectious disease.
Coverage Duration	8 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Colorectal Cancer (CRC): Diagnosis of advanced or metastatic CRC. Trial, contraindication, or intolerance to treatment with all of the following: fluoropyrimidine-based chemotherapy, oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, and anti-VEGF biological therapy (e.g., bevacizumab). One of the following: a) tumor is RAS mutant-type or b) tumor is RAS wild-type and Trial, contraindication, or intolerance to one anti-EGFR therapy (eg, Vectibix [panitumumab], Erbitux [cetuximab]). Gastric/Gastroesophageal Junction Adenocarcinoma: Diagnosis of one of the following: a) unresectable locally advanced, recurrent, or metastatic gastric cancer, or b) unresectable locally advanced, recurrent, or metastatic gastroesophageal junction adenocarcinoma. Trial, contraindication, or intolerance to treatment with at least two prior lines of chemotherapy that consisted of the following agents: fluropyrimidine (e.g. fluorouracil), Platinum (e.g., carboplatin, cisplatin, oxaliplatin), Taxane (e.g., docetaxel, paclitaxel) or irinotecan, HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. One of the following: A) Disease is advanced, metastatic, or recurrent and anaplastic lymphoma kinase (ALK)-positive OR B) Both of the following: 1) Disease is both of the following: i) advanced, metastatic, or recurrent and ii) ROS proto-oncogene 1 (ROS1)-positive AND 2) Disease has progressed on at least one of the following therapies: Augtyro (repotrectinib), Xalkori (crizotinib), Rozlytrek (entrectinib), or Zykadia (ceritinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) recurrent, b) advanced or c) metastatic. Tumor is KRAS G12C-mutated. Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy). Metastatic Colorectal Cancer (mCRC): Diagnosis of mCRC. Tumor is KRAS G12C-mutated. Patient has received at least one prior systemic therapy (e.g., immune checkpoint inhibitor, platinum-based chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LUMRYZ

Products Affected

- Lumryz
- Lumryz Starter Pack

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LUPRON DEPOT

Products Affected

- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

LYNKUET

Products Affected

- Lynkuet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of moderate to severe vasomotor symptoms due to menopause. Prescriber attests that baseline serum alanine aminotransferase (ALT), serum aspartate aminotransferase (AST) and total bilirubin levels are less than 2 times the upper limit of normal (ULN) prior to initiating Lynkuet.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: Plan Year.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Provider attests that patient's liver tests will be closely monitored for abnormalities throughout therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LYNPARZA (TABLETS)

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	High risk early breast cancer: Diagnosis of high risk early breast cancer. Presence of deleterious or suspected deleterious germline BRCA-mutations. Disease is human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) Disease is hormone receptor (HR)-negative, OR b) Both of the following: i) Disease is HR-positive AND ii) Patient is continuing concurrent treatment with endocrine therapy. Patient has been previously treated with neoadjuvant or adjuvant chemotherapy (e.g., anthracycline, taxane). Metastatic or recurrent breast cancer: Diagnosis of breast cancer. Disease is metastatic or recurrent. Presence of deleterious or suspected deleterious germline BRCA-mutations. Disease is human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) Disease is hormone receptor (HR) negative, or b) Disease is hormone receptor (HR)-positive and one of the following: i) disease has progressed on previous endocrine therapy or ii) provider attestation that treatment with endocrine therapy is inappropriate for the patient's disease. Pancreatic adenocarcinoma: Diagnosis of pancreatic adenocarcinoma. Disease is metastatic. Presence of deleterious or suspected deleterious germline BRCA-mutations. Disease has not progressed while receiving at least 16 weeks of a first-line platinum-based chemotherapy regimen (e.g., FOLFIRINOX, FOLFOX, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year

Other Criteria	Ovarian cancer (Maintenance Therapy): Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Disease is one of the following: advanced or recurrent. One of the following: 1) Patient has had a complete or partial response to platinum-based chemotherapy (e.g., carboplatin, cisplatin), or 2) Both of the following: a) patient has had a complete or partial response to first-line platinum-based chemotherapy (e.g., carboplatin, cisplatin) AND b) one of the following: i) presence of deleterious or suspected deleterious germline or somatic BRCA-mutations OR ii) both of the following: cancer is associated with homologous recombination deficiency (HRD)-positive status defined by either a deleterious or suspected deleterious BRCA mutation or genomic instability AND used in combination with bevacizumab (e.g., Avastin, Myvasi). Will be used as maintenance therapy. Prostate cancer: Diagnosis of metastatic castration-resistant prostate cancer. One of the following: 1) Both of the following: a) Presence of deleterious or suspected deleterious homologous recombination repair (HRR) gene mutations and b) Disease has progressed following prior treatment with one of the following: i) enzalutamide (Xtandi), or ii) abiraterone (e.g., Zytiga, Yonsa), OR 2) All of the following: a) Presence of deleterious or suspected deleterious BRCA-mutation, b) Used in combination with abiraterone (e.g., Zytiga, Yonsa), and c) Used in combination with prednisone or prednisolone. One of the following: 1) used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)], or 2) Patient has had bilateral orchiectomy. All indications: Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LYTGOBI

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cholangiocarcinoma (intrahepatic or extrahepatic). Disease is one of the following: a) unresectable, b) locally advanced, c) Resected gross residual (R2), or d) metastatic. Positive for fibroblast growth factor receptor 2 (FGFR2) fusions or other rearrangements. Used as second line or subsequent treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: 1) One of the following: a) Diagnosis of hepatitis C, or b) Patient was not infected with hepatitis C virus prior to receiving an organ transplant, and patient received a liver or non-liver organ transplant from a donor with a diagnosis of hepatitis C, 2) patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and 3) not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	8 to 16 weeks. Criteria applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma AND cancer is BRAF V600 mutant type. Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type. Involvement of lymph nodes following complete resection. Used as adjuvant therapy. Medication is used in combination with Tafinlar (dabrafenib). Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of non-small cell lung cancer AND disease is one of the following: metastatic, advanced, or recurrent AND cancer is BRAF V600E mutant type AND medication is used in combination with Tafinlar (dabrafenib). Anaplastic Thyroid Cancer (ATC): Diagnosis of ATC. One of the following: 1) Disease is one of the following: metastatic, locally advanced, or unresectable OR 2) Prescribed as adjuvant therapy following resection. Cancer is BRAF V600E mutant type. Medication is used in combination with Tafinlar (dabrafenib). Solid tumors: Presence of solid tumor. Disease is unresectable or metastatic. Patient has progressed on or following prior systemic treatment (e.g., carboplatin, 5-fluorouracil, paclitaxel). Cancer is BRAF V600E mutant type. Medication is used in combination with Tafinlar (dabrafenib). Low-grade glioma: Diagnosis of low-grade glioma. Cancer is BRAF V600E mutant type. Medication is used in combination with Tafinlar (dabrafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Patient is positive for BRAF V600 mutation. Used in combination with Braftovi (encorafenib). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: recurrent, advanced, or metastatic. Patient is positive for BRAF V600 mutation. Used in combination with Braftovi (encorafenib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MEMANTINE - DONEPEZIL/MEMANTINE

Products Affected

- Memantine/donepezil Hydrochloride Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Age 41 or older, or diagnosis of moderate to severe dementia of the Alzheimer's type.
Age Restrictions	No Prior Authorization if patient is age 41 or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEMANTINE - MEMANTINE

Products Affected

- Memantine Hydrochloride SOLN 2MG/ML
- Memantine Hydrochloride TABS
- Memantine Hydrochloride Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Age 41 or older, or diagnosis of moderate to severe dementia of the Alzheimer's type.
Age Restrictions	No Prior Authorization if patient is age 41 or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

METYROSINE

Products Affected

- Metyrosine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pheochromocytoma for preoperative preparation of patients for surgery, management of patients when surgery is contraindicated, or chronic treatment of patients with malignant pheochromocytoma.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Plan Year.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MIGLUSTAT

Products Affected

- Miglustat
- Yargesa

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MODAFINIL

Products Affected

- Modafinil TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

MODEYSO

Products Affected

- Modeyso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: Diffuse midline glioma or high-grade glioma. Disease is positive for H3 K27M mutation. Disease is one of the following: recurrent or progessive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MOUNJARO

Products Affected

- Mounjaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for weight loss only.
Required Medical Information	Diabetes Mellitus (DM): Submission of medical records (e.g., chart notes) confirming diagnosis of type 2 DM.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MRESVIA

Products Affected

- Mresvia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vaccine is being used for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV). Patient has not received an RSV vaccine (i.e., Abrysvo, Arexvy, MRESVIA) in their lifetime. One of the following: a) Age greater than or equal to 60 years, or b) Both of the following: 1) Age 18 through 59 years, and 2) Patient is at increased risk for LRTD caused by RSV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NAYZILAM

Products Affected

- Nayzilam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epilepsy: Diagnosis of epilepsy. Frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NINTEDANIB

Products Affected

- Nintedanib Esylate

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-metastatic castration-resistant or castration-recurrent prostate cancer (NM-CRPC): Diagnosis of non-metastatic castration-resistant (chemical or surgical) or castration-recurrent prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Zoladex [goserelin], Vantas [histrelin], Lupron [leuprolide], Trelstar [triptorelin], Firmagon [degarelix]) OR 2) Patient received bilateral orchiectomy. Metastatic castration-sensitive prostate cancer (mCSPC): Diagnosis of mCSPC [also known as metastatic hormone-sensitive prostate cancer (mHSPC)]. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog (e.g., Zoladex [goserelin], Vantas [histrelin], Lupron [leuprolide], Trelstar [triptorelin], Firmagon [degarelix]) OR 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	NM-CRPC, mCSPC: Plan year
Other Criteria	NM-CRPC, mCSPC: Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NUPLAZID

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NURTEC

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

NUZYRA (IV)

Products Affected

- Nuzyra INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Community-acquired bacterial pneumonia (CABP): Diagnosis of CABP caused by one of the following: methicillin-susceptible Staphylococcus aureus (MSSA), Streptococcus pneumoniae, Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophila, Mycoplasma pneumoniae, or Chlamydophila pneumoniae. Acute bacterial skin and skin structure infection (ABSSSI): Patient is unable to take oral Nuzyra tablets AND one of the following: 1) Diagnosis of ABSSSI caused by methicillin-resistant Staphylococcus aureus (MRSA) OR empirical treatment of patients with ABSSSI where presence of MRSA infection is likely. OR 2) Diagnosis of ABSSSI caused by one of the following: MSSA, Staphylococcus lugdunensis, Streptococcus pyogenes, Streptococcus anginosus grp. (includes S. anginosus, S. intermedius, S. constellatus), Enterococcus faecalis, Enterobacter cloacae, or Klebsiella pneumoniae.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CABP, ABSSSI: 14 days
Other Criteria	CABP: Approve for continuation of Nuzyra therapy upon hospital discharge (patients who are transitioning from the hospital are allowed to continue use of the drug and other prior authorization requirements do not apply) when patient is unable to take oral Nuzyra tablets. ABSSSI: Approve for continuation of Nuzyra therapy upon hospital discharge (patients who are transitioning from the hospital are allowed to continue use of the drug and other prior authorization requirements do not apply).

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUZYRA (ORAL)

Products Affected

- Nuzyra TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Community-acquired bacterial pneumonia (CABP): Diagnosis of CABP caused by one of the following: methicillin-susceptible Staphylococcus aureus (MSSA), Streptococcus pneumoniae, Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophila, Mycoplasma pneumoniae, or Chlamydophila pneumoniae. Acute bacterial skin and skin structure infection (ABSSSI): One of the following: 1) Diagnosis of ABSSSI caused by methicillin-resistant Staphylococcus aureus (MRSA) OR empirical treatment of patients with ABSSSI where presence of MRSA infection is likely. OR 2) Diagnosis of ABSSSI caused by one of the following: MSSA, Staphylococcus lugdunensis, Streptococcus pyogenes, Streptococcus anginosus grp. (includes S. anginosus, S. intermedius, S. constellatus), Enterococcus faecalis, Enterobacter cloacae, or Klebsiella pneumoniae.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CABP, ABSSSI: 14 days
Other Criteria	CABP: Approve for continuation of Nuzyra therapy upon hospital discharge (patients who are transitioning from the hospital are allowed to continue use of the drug and other prior authorization requirements do not apply). ABSSSI: Approve for continuation of Nuzyra therapy upon hospital discharge or as continuation of therapy when transitioning from intravenous antibiotics given in the hospital for the requested indication (e.g., daptomycin, vancomycin, linezolid) (patients who are transitioning from the hospital or from intravenous antibiotics given in the hospital are allowed to continue use of the drug and other prior authorization requirements do not apply).

Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OCTREOTIDE

Products Affected

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

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced basal cell carcinoma: Diagnosis of basal cell carcinoma. Disease is locally advanced. One of the following: 1) Disease has recurred following surgery or radiation therapy or 2) Patient is not a candidate for surgery or radiation therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OFEV (BRAND)

Products Affected

- Ofev

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OGSIVEO

Products Affected

- Ogsiveo TABS 100MG, 150MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of desmoid tumor. Patient requires systemic treatment. Disease is progressive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJEMDA

Products Affected

- Ojemda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pediatric low-grade glioma. Disease is relapsed or refractory. Presence of a BRAF fusion or rearrangement, or BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJJAARA

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Diagnosis of symptomatic lower-risk myelofibrosis, OR B) Both of the following: 1) Diagnosis of higher risk myelofibrosis, AND 2) One of the following: i) All of the following: a) Patient is not a transplant candidate or transplant not currently feasible, b) Platelets greater than or equal to 50 x 10^9/L, c) Presence of symptomatic splenomegaly and/or constitutional symptoms, OR ii) Both of the following: a) Patient is not a transplant candidate or transplant not currently feasible, b) Platelets less than 50 x 10^9/L, OR C) Diagnosis of myelofibrosis-associated anemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of acute myeloid leukemia (AML). Patient has received previous treatment with an intensive induction chemotherapy regimen (e.g., cytarabine + daunorubicin, cytarabine + idarubicin). Patient has achieved one of the following: a) first complete remission (CR) or b) complete remission with incomplete blood count recovery (CRi). Patient is not able to complete intensive curative therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OPIPZA

Products Affected

- Opipza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of Schizophrenia. Trial, contraindication, or intolerance (T/C/I) to two of the following: a) aripiprazole (contraindication is not required), b) olanzapine, c) quetiapine IR/ER, d) risperidone, e) clozapine, f) ziprasidone, g) paliperidone, or h) asenapine. Major Depressive Disorder (MDD): Diagnosis of MDD. Both of the following: a) T/C/I to quetiapine IR/ER and b) trial or intolerance to aripiprazole. Autism: Diagnosis of irritability associated with autistic disorder. Both of the following: a) Trial, contraindication (e.g., age), or intolerance to risperidone and b) trial or intolerance to aripiprazole. Tourette's Syndrome: Diagnosis of Tourette's Syndrome. Trial or intolerance to aripiprazole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OPSUMIT

Products Affected

- Macitentan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORENITRAM

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORKAMBI

Products Affected

- Orkambi TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ORKAMBI GRANULES

Products Affected

- Orkambi PACK

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ORSERDU

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer. Disease is advanced or metastatic. One of the following: a) Patient is male, b) Patient is a postmenopausal woman, or c) Patient is a premenopausal woman treated with ovarian ablation/suppression. Disease is estrogen receptor (ER)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Presence of estrogen receptor (ESR1) mutation(s). Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OSPHENA

Products Affected

- Osphena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Dyspareunia: Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Vaginal dryness: Diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OTEZLA

Products Affected

- Otezla

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OTEZLA XR

Products Affected

- Otezla Xr
- Otezla/otezla Xr 28 Day Treatment Initiation Pack

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OZEMPIC

Products Affected

- Ozempic INJ 2MG/3ML, 4MG/3ML, 8MG/3ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

OZEMPIC TABLET

Products Affected

- Ozempic TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for weight loss only.
Required Medical Information	Diabetes Mellitus (DM): Submission of medical records (e.g., chart notes) confirming diagnosis of type 2 DM.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PANRETIN

Products Affected

- Panretin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Kaposi's sarcoma lesions: Diagnosis of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma (KS). Not used when systemic anti-KS therapy is required (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PEGFILGRASTIM PREFERRED

Products Affected

- Neulasta INJ 6MG/0.6ML
- Udenyca

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PEGINTERFERON ALFA - 2A

Products Affected

- Pegasys

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Hepatitis B: Diagnosis of chronic hepatitis B infection. Chronic Hepatitis C: Diagnosis of chronic hepatitis C infection. Patient has compensated liver disease. One of the following: a) Used in combination with one other hepatitis C virus (HCV) antiviral drug (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin) OR b) Both of the following: Used as monotherapy AND contraindication or intolerance to all other HCV antiviral drugs (e.g., Mavyret [glecaprevir-pibrentasvir], ribavirin).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HepB, HepC: 48 wks.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is one of the following: unresectable locally advanced, resected gross residual (R2), or metastatic. Presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement. Patient has been previously treated. Myeloid/Lymphoid neoplasms: Diagnosis of myeloid/lymphoid/mixed lineage neoplasms with eosinophilia. Presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer (BC): Diagnosis of advanced or metastatic BC. Disease is hormone receptor (HR)-positive, and human epidermal growth factor receptor 2 (HER2)-negative. Presence of one or more PIK3CA mutations. Used in combination with fulvestrant. Disease has progressed on or after an endocrine-based regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PIRFENIDONE

Products Affected

- Pirfenidone CAPS
- Pirfenidone TABS 267MG, 801MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

POLYPHARMACY-ACH - AMITRIPTYLINE

Products Affected

- Amitriptyline Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - AMOXAPINE

Products Affected

- Amoxapine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - ATROPINE/DIPHENOXYLATE

Products Affected

- Diphenoxylate Hydrochloride/atropine Sulfate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - BENZTROPINE

Products Affected

- Benztropine Mesylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - CHLORPROMAZINE

Products Affected

- Chlorpromazine Hydrochloride CONC
- Chlorpromazine Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - CLOMIPRAMINE

Products Affected

- Clomipramine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - CLOZAPINE

Products Affected

- Clozapine TABS 100MG, 200MG, 25MG, 50MG
- Clozapine Odt
- Versacloz

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - CYCLOBENZAPRINE

Products Affected

- Cyclobenzaprine Hydrochloride TABS 10MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - DESIPRAMINE

Products Affected

- Desipramine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - DICYCLOMINE

Products Affected

- Dicyclomine Hcl SOLN
- Dicyclomine Hydrochloride CAPS
- Dicyclomine Hydrochloride TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - DOXEPIN

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - HYDROXYZINE

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - IMIPRAMINE

Products Affected

- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - MECLIZINE

Products Affected

- Meclizine Hcl TABS 12.5MG
- Meclizine Hydrochloride TABS 25MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - NORTRIPTYLINE

Products Affected

- Nortriptyline Hcl CAPS 25MG, 75MG
- Nortriptyline Hcl SOLN
- Nortriptyline Hydrochloride CAPS 10MG, 50MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - OLANZAPINE

Products Affected

- Olanzapine TABS
- Olanzapine Odt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - OLANZAPINE/SAMIDORPHAN

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - OXYBUTYNIN

Products Affected

- Oxybutynin Chloride SOLN
- Oxybutynin Chloride TABS 5MG
- Oxybutynin Chloride Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - PAROXETINE

Products Affected

- Paroxetine Hcl TABS 30MG, 40MG
- Paroxetine Hydrochloride SUSP
- Paroxetine Hydrochloride TABS 10MG, 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - PERPHENAZINE

Products Affected

- Perphenazine TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - PROCHLORPERAZINE

Products Affected

- Prochlorperazine SUPP 25MG
- Prochlorperazine Maleate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - PROMETHAZINE

Products Affected

- Promethazine Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - SCOPOLAMINE

Products Affected

- Scopolamine PT72 1MG/3DAYS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - SOLIFENACIN

Products Affected

- Solifenacin Succinate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - TOLTERODINE

Products Affected

- Tolterodine Tartrate
- Tolterodine Tartrate Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POLYPHARMACY-ACH - TRIHEXYPHENIDYL

Products Affected

- Trihexyphenidyl Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the patient.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

POMALYST

Products Affected

- Pomalidomide
- Pomalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. One of the following: 1) Trial, contraindication, or intolerance to one of the following: a) immunomodulatory agent (eg, lenalidomide), b) proteasome inhibitor (eg, bortezomib), or c) anti CD-38 therapy [eg, Darzalex (daratumumab), Sarclisa (isatuximab)], OR 2) Induction therapy for the management of POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome. Kaposi sarcoma (KS): One of the following: 1) Both of the following: a) Diagnosis of AIDS-related KS and b) Patient is currently being treated with antiretroviral therapy (ART), OR 2) Both of the following: a) Diagnosis of KS and b) Patient is HIV-negative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

POSACONAZOLE ORAL

Products Affected

- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of Invasive Fungal Infections (IFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy [eg, acute myeloid leukemia (AML), myelodysplastic syndrome (MDS)], OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Treatment of IFI: Used as treatment of invasive fungal infections caused by Aspergillus.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prophylaxis of IFI: plan year. Treatment of IFI: 3 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PREGABALIN IR

Products Affected

- Pregabalin CAPS
- Pregabalin SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Neuropathic pain: Diagnosis of neuropathic pain associated with one of the following: a) Diabetic peripheral neuropathy, or b) Spinal cord injury. Seizures: Diagnosis of partial-onset seizures. Medication is being used as adjunctive therapy. Postherpetic neuralgia (PNH): Diagnosis of PNH. Trial, contraindication or intolerance to generic gabapentin. Fibromyalgia: Diagnosis of fibromyalgia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PREVYMIS ORAL

Products Affected

- Prevymis PACK
- Prevymis TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cytomegalovirus (CMV) Prophylaxis in Hematopoietic Stem Cell Transplant (HSCT): Used for prophylaxis of CMV infection and disease AND patient is a CMV-seropositive recipient [R+] of an allogeneic HSCT. CMV Prophylaxis in Kidney Transplant: Used for prophylaxis CMV infection and disease. Patient is a CMV-seronegative recipient [R-]. Patient is receiving a kidney transplant from a CMV-seropositive donor [D+].
Age Restrictions	N/A
Prescriber Restrictions	CMV Prophylaxis in HSCT: Prescribed by or in consultation with an oncologist, hematologist, physician experienced in the management of transplant patients, or infectious disease specialist. CMV Prophylaxis in Kidney Transplant: Prescribed by or in consultation with a nephrologist, physician experienced in the management of transplant patients, or infectious disease specialist.
Coverage Duration	CMV Prophylaxis in HSCT: 7 months. CMV Prophylaxis in Kidney Transplant: 7 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PROMACTA

Products Affected

- Eltrombopag Olamine

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PURIXAN

Products Affected

- Mercaptopurine SUSP

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) History of contraindication or intolerance to generic mercaptopurine tablets, 2) patient is unable to swallow a solid oral dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube), OR 3) Dosage requirements cannot be met with a solid dosage form.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PYRIMETHAMINE TABLET

Products Affected

- Pyrimethamine TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Primary toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia (PCP) prophylaxis, and secondary cystoisosporiasis prophylaxis: Diagnosis of one of the following: a) Primary toxoplasmosis prophylaxis, b) PCP prophylaxis, or c) Secondary cystoisosporiasis prophylaxis. The patient has experienced an intolerance or has a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX). The patient is immunocompromised. Secondary toxoplasmosis prophylaxis: Diagnosis of secondary toxoplasmosis prophylaxis. The patient is immunocompromised. Cystoisosporiasis treatment: Diagnosis of cystoisosporiasis. The patient has experienced an intolerance or has a contraindication to TMP-SMX. For continuation of therapy upon hospital discharge (patients who are transitioning from the hospital are allowed to continue use of the drug and other prior authorization requirements do not apply).
Age Restrictions	N/A
Prescriber Restrictions	All Indications: Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	All Indications: Plan Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PYRUKYND

Products Affected

- Pyrukynd
- Pyrukynd Taper Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of hemolytic anemia confirmed by the presence of chronic hemolysis (e.g., increased indirect bilirubin, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count). Diagnosis of pyruvate kinase deficiency confirmed by molecular testing of ALL the following mutations on the PKLR gene: a) Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 was a missense variant AND b) Patients is not homozygous for the c.1436G to A (p.R479H) variant AND c) Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene. Hemoglobin is less than or equal to 10g/dL. Patient has symptomatic anemia or is transfusion dependent. Exclusion of other causes of hemolytic anemias (e.g., infections, toxins, drugs).
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 6 months. Reauth: Plan Year.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal Stromal Tumor (GIST): Diagnosis of gastrointestinal stromal tumor (GIST). One of the following: a) gross residual disease (R2 resection), b) tumor rupture, c) unresectable primary disease, or d) recurrent/metastatic. One of the following: a) History of progression on all of the following: imatinib (Gleevec), sunitinib (Sutent), and regorafenib (Stivarga), b) Both of the following: history of progression on imatinib (Gleevec), and history of intolerance to sunitinib (Sutent), or c) All of the following: PDGFRA exon 18 mutations that are insensitive to imatinib (Gleevec) (including PDGFRA D842V), history of progression on avapritinib (Ayvakit), and history of progression on dasatinib (Sprycel).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

QUETIAPINE ER TABLETS

Products Affected

- Quetiapine Fumarate Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Schizophrenia: Diagnosis of schizophrenia. Trial, contraindication, or intolerance to one of the following: a) olanzapine, b) aripiprazole, or c) quetiapine IR (contraindication not required). Bipolar Disorder: Diagnosis of one of the following: a) Bipolar I disorder, manic or mixed episodes, b) bipolar disorder, depressive episodes. Trial, contraindication, or intolerance to one of the following: a) olanzapine, b) aripiprazole, or c) quetiapine IR (contraindication not required). Major Depressive Disorder (MDD): Diagnosis of MDD. Medication is being used as adjunctive therapy with antidepressants (e.g, citalopram, fluoxetine, etc.). Trial, contraindication, or intolerance to one of the following: a) olanzapine, b) aripiprazole, or c) quetiapine IR (contraindication not required)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

QUININE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis (dx) of uncomplicated malaria and one of the following: treatment in areas of chloroquine-sensitive malaria or treatment in areas of chloroquine-resistant malaria.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	Chloroquine-sensitive malaria: Trial, contraindication or intolerance to chloroquine or hydroxychloroquine.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RADICAVA ORS

Products Affected

- Radicava Ors Starter Kit

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RELGAABI

Products Affected

- Gabapentin CAPS 200MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RETEVMO

Products Affected

- Retevmo TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) recurrent, b) advanced, or c) metastatic. Presence of RET gene fusion-positive or RET rearrangement positive tumor(s). Thyroid Cancer: One of the following: a) All of the following: Diagnosis of medullary thyroid cancer (MTC), Disease is advanced or metastatic, Disease has presence of RET gene mutation, AND Disease requires treatment with systemic therapy, OR b) All of the following: Diagnosis of thyroid cancer, Disease is advanced or metastatic, Disease is RET gene fusion-positive, Disease requires treatment with systemic therapy, AND Patient is radioactive iodine-refractory or treatment with radioactive iodine therapy is not appropriate. Solid Tumors: Presence of RET gene fusion-positive solid tumor. Disease is recurrent, advanced, or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	NSCLC, Thyroid Cancer, Solid Tumors: Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVCOVI

Products Affected

- Revcovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency (SCID).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVUFORJ

Products Affected

- Revuforj

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Relapsed or refractory acute leukemia: Diagnosis of acute leukemia. Disease is relapsed or refractory. Positive for lysine methyltransferase 2A gene (KMT2A) translocation. Relapsed or refractory acute myeloid leukemia: Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Positive for nucleophosmin 1 (NPM1) mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZDIFFRA

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

REZLIDHIA

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Positive for a susceptible isocitrate dehydrogenase-1 (IDH1) mutation (e.g., R132C, R132H, R132G, R132S, R132L).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

RINVOQ LQ

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ROFLUMILAST

Products Affected

- Roflumilast

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD) (initial): Diagnosis of COPD. History of COPD exacerbations which required the use of systemic corticosteroids (e.g., prednisone), antibiotics, or hospital admission. Trial, intolerance, or contraindication to two prior therapies for COPD (e.g., Combivent, Spiriva).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: plan year
Other Criteria	COPD (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ROMVIMZA

Products Affected

- Romvimza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of tenosynovial giant cell tumor (TGCT). Surgical resection will potentially cause worsening functional limitation or severe morbidity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic non-small cell lung cancer (NSCLC). Patient has ROS1 rearrangement positive tumor(s). Solid Tumors: Patient has solid tumors with a neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, TPR-NTRK1, etc.). Disease is without a known acquired resistance mutation (e.g., TRKA G595R, TRKA G667C or TRKC G623R substitutions). Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Used for maintenance treatment in patients who are in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin). Presence of deleterious BRCA mutation. Metastatic castration-resistant prostate cancer (mCRPC): Diagnosis of mCRPC. Presence of deleterious BRCA mutation. Trial, contraindication, or intolerance to androgen receptor-directed therapy [e.g., Erleada (apalutamide), Xtandi (enzalutamide), abiraterone]. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)], OR 2) Patient received bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RUFINAMIDE

Products Affected

- Rufinamide SUSP 40MG/ML
- Rufinamide TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS). Trial, contraindication, or intolerance to one of the following: clonazepam/ODT, felbamate, lamotrigine IR, or topiramate IR.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of acute myeloid leukemia (AML), AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive, Rydapt will be used in combination with standard induction and consolidation therapy. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SCEMBLIX

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous/myeloid leukemia (CML). Disease is Philadelphia chromosome-positive (Ph+) or BCR::ABL1-positive. Disease is in chronic phase or disease is in accelerated phase.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cushing's disease: Diagnosis of endogenous Cushing's disease (i.e, hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Either pituitary surgery has not been curative for the patient OR patient is not a candidate for pituitary surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SILDENAFIL

Products Affected

- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pulmonary tuberculosis (TB). Adverse reactions or resistance to standard drugs used to treat MDR-TB. Patient has Mycobacterium tuberculosis resistant to at least rifampin and isoniazid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SKYCLARYS

Products Affected

- Skyclarys

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SKYRIZI

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 55MG/0.37ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

SORAFENIB

Products Affected

- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. Hepatocellular carcinoma (HCC): Diagnosis of HCC. One of the following: patient has metastatic disease, or patient has extensive liver tumor burden, or patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only), or both of the following: a) patient is not a transplant candidate, and b) disease is unresectable. Differentiated thyroid carcinoma (DTC): Diagnosis of one of the following: a) follicular carcinoma, b) oncocytic carcinoma, or c) papillary carcinoma. One of the following: metastatic disease, unresectable recurrent disease, or persistent locoregional disease. One of the following: patient has symptomatic disease or patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SPRYCEL

Products Affected

- Dasatinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic Myeloid Leukemia (CML): Diagnosis of chronic myeloid leukemia (CML). Acute Lymphoblastic Leukemia (ALL): Diagnosis of acute lymphoblastic leukemia (ALL).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

STARJEMZA

Products Affected

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

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

STEQEYMA

Products Affected

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

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Colorectal Cancer (CRC): Diagnosis of advanced or metastatic colorectal cancer. Trial, contraindication, or intolerance to treatment with all the following: oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, fluoropyrimidine-based chemotherapy, and anti-VEGF therapy-based chemotherapy (e.g., aflibercept, bevacizumab, ramucirumab). One of the following: 1) Tumor is RAS mutant-type OR 2) Tumor is RAS wild-type and trial, contraindication, or intolerance to anti-EGFR therapy [e.g., Erbitux (cetuximab), Vectibix (panitumumab)]. Gastrointestinal stromal tumor (GIST): Diagnosis of gross residual (R2 resection), unresectable primary, tumor rupture, or recurrent/metastatic GIST. One of the following: 1) Patient has succinate dehydrogenase (SDH) deficient GIST or 2) Trial, contraindication, or intolerance to imatinib mesylate and sunitinib malate. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Used as subsequent-line therapy for disease progression.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SUNITINIB

Products Affected

- Sunitinib Malate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. One of the following: 1) History of disease progression on, contraindication, or intolerance to Gleevec (imatinib), Stivarga (regorafenib), or standard dose Qinlock (ripretinib) or 2) Succinate dehydrogenase (SDH)-deficient GIST. Renal Cell Carcinoma (RCC): Diagnosis of RCC. One of the following: 1) Disease has relapsed, 2) Both of the following: used in adjuvant setting and patient has a high risk of recurrence following nephrectomy, or 3) Disease is advanced. Islet Cell Tumors/Pancreatic Neuroendocrine Tumors (pNET): Diagnosis of islet cell tumors/progressive pNET.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Lennox-Gastaut syndrome: Diagnosis of Lennox-Gastaut syndrome. Used for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome. Dravet syndrome: Diagnosis of seizures associated with Dravet syndrome (DS). Used in combination with Diacomit.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TABLOID

Products Affected

- Tabloid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). One of the following: a) Presence of mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors or b) High level MET amplification in lung cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TADALAFIL (BPH)

Products Affected

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for the treatment of erectile dysfunction only.
Required Medical Information	Diagnosis of benign prostatic hyperplasia. Male gender. Trial, contraindication, or intolerance to two formulary alpha blockers (e.g., tamsulosin, alfuzosin). 2.5mg strength: Patient has renal insufficiency.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TADALAFIL (PAH)

Products Affected

- Alyq
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAFAMIDIS

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) (initial): Diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM). One of the following: 1) Presence of a transthyretin (TTR) mutation (e.g., V122I), 2) Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits, OR 3) Both of the following: i) cardiac magnetic resonance imaging or scintigraphy scan suggestive of amyloidosis, and ii) absence of light-chain amyloidosis. Documentation that patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure.
Age Restrictions	N/A
Prescriber Restrictions	ATTR-CM (initial): Prescribed by or in consultation with a cardiologist
Coverage Duration	ATTR-CM (initial, reauth): Plan year
Other Criteria	ATTR-CM (reauth): Patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma AND cancer is BRAFV600 mutant type. Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type. Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Mekinist (trametinib). Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of non-small cell lung cancer AND disease is one of the following: metastatic, advanced, or recurrent AND cancer is BRAF V600E mutant type AND medication is used in combination with Mekinist (trametinib). Anaplastic Thyroid Cancer (ATC): Diagnosis of anaplastic thyroid cancer. One of the following: 1) Disease is one of the following: metastatic, locally advanced, or unresectable OR 2) Prescribed as adjuvant therapy following resection. Cancer is BRAF V600E mutant type. Medication is used in combination with Mekinist (trametinib). Solid tumors: Presence of solid tumor. Disease is unresectable or metastatic. Patient has progressed on or following prior systemic treatment (e.g., carboplatin, 5-fluorouracil, paclitaxel). Cancer is BRAF V600E mutant type. Medication is used in combination with Mekinist (trametinib). Low-grade glioma: Diagnosis of low-grade glioma. Cancer is BRAF V600E mutant type. Medication is used in combination with Mekinist (trametinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Disease is one of the following: a) locally advanced or b) metastatic. Presence of a germline BRCA-mutation. Prostate cancer: Diagnosis of prostate cancer. Disease is HRR gene-mutated. Disease is metastatic castration-resistant. Taken in combination with Xtandi (enzalutamide). Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] OR Patient has had bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TARPEYO

Products Affected

- Tarpeyo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TASIGNA

Products Affected

- Nilotinib Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myeloid leukemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TASIMELTEON CAPSULE

Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-24-hour sleep-wake disorder: Diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome). Smith-Magenis Syndrome (SMS): Diagnosis of Smith-Magenis Syndrome (SMS). Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking).
Age Restrictions	SMS: 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Non-24, SMS: 6 months
Other Criteria	Non-24: Patient is totally blind (has no light perception).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAZAROTENE

Products Affected

- Tazarotene CREA 0.1%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All indications: Excluded if treatment for cosmetic purposes.
Required Medical Information	Acne vulgaris: Diagnosis of acne vulgaris (i.e., acne). Psoriasis: Diagnosis of psoriasis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of non-small cell lung cancer (NSCLC). Disease is one of the following: recurrent, advanced, or metastatic. One of the following: 1) Mesenchymal-epithelial transition (MET) exon 14 skipping mutation positive tumor(s) or 2) High level MET amplification.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TERIPARATIDE

Products Affected

- Bonsity
- Teriparatide

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TESTOSTERONE CYPIONATE

Products Affected

- Testosterone Cypionate INJ 100MG/ML, 200MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Male Hypogonadism (HG): Diagnosis of primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired). Patient is male at birth.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TESTOSTERONE ENANTHATE

Products Affected

- Testosterone Enanthate INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Male Hypogonadism (HG): Diagnosis of primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired). Male patient at birth. Delayed puberty (DP): Diagnosis of male DP. Male patient at birth. Metastatic breast cancer: Diagnosis of advancing inoperable metastatic (skeletal) mammary (breast) cancer. Female patient at birth.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Huntington's Disease: Diagnosis of chorea in patients with Huntington's disease. Tardive dyskinesia (TD): Diagnosis of TD. One of the following: 1) Patient has persistent symptoms of TD despite a trial of dose reduction, tapering, or discontinuation of the offending medication or 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Tourette's syndrome: Patient has tics associated with Tourette's syndrome. Trial, contraindication, or intolerance to Haldol (haloperidol).
Age Restrictions	TD: Patient is 18 years of age or older.
Prescriber Restrictions	Huntington's: Prescribed by or in consultation with a neurologist. TD, Tourette's: Prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	Huntington's, TD, Tourette's: Plan Year.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TEZSPIRE

Products Affected

- Tezspire

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

THALOMID

Products Affected

- Thalomid CAPS 100MG, 50MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Erythema Nodosum Leprosum (ENL): Diagnosis (Dx) of moderate to severe ENL. One of the following: used for acute treatment OR used as maintenance therapy for prevention and suppression of cutaneous manifestations of ENL recurrence. Multiple Myeloma (MM): Dx of multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TOBI PODHALER

Products Affected

- Tobi Podhaler

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TOFACITINIB

Products Affected

- Tofacitinib Citrate SOLN
- Tofacitinib Citrate TABS
- Tofacitinib Citrate Er

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TOLVAPTAN (SAMSCA)

Products Affected

- Tolvaptan TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of significant hyponatremia (euvolemic or hypervolemic). Treatment has been initiated or re-initiated in a hospital setting prior to discharge within the past 30 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Length of authorization: 30 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TOPICAL RETINOIDS - TRETINOIN

Products Affected

- Tretinoin CREA
- Tretinoin GEL 0.01%, 0.025%
- Tretinoin Microsphere GEL 0.1%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	All indications: Excluded if treatment for cosmetic purposes.
Required Medical Information	Acne vulgaris: Diagnosis of acne vulgaris (i.e., acne).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TREMFYA

Products Affected

- Tremfya INJ 100MG/ML, 200MG/2ML
- Tremfya Induction Pack For Crohns Disease/ulcerative Colitis

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRIENTINE

Products Affected

- Trientine Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TRULICITY

Products Affected

- Trulicity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for weight loss only.
Required Medical Information	Diabetes Mellitus (DM): Submission of medical records (e.g., chart notes) confirming diagnosis of type 2 DM.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRUQAP

Products Affected

- Truqap TABS 200MG
- Truqap TBPK 160MG

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Diagnosis of breast cancer. Disease is one of the following: a) advanced unresectable or b) metastatic. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Used in combination with trastuzumab and capecitabine. Patient has been previously treated with an anti-HER2-based regimen (e.g., trastuzumab, pertuzumab, ado-trastuzumab emtansine) in the metastatic setting. Colorectal cancer: Diagnosis of colorectal cancer (HER2-amplified and RAS and BRAF wild-type). Disease is HER2-positive. Disease is one of the following: a) advanced, b) unresectable, c) metastatic. One of the following: a) patient has previously been treated with one of the following regimens: i) fluoropyrimidine-based chemotherapy, ii) oxaliplatin-based chemotherapy, iii) irinotecan-based chemotherapy or b) patient is not appropriate for intensive therapy. Used in combination with trastuzumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TURALIO

Products Affected

- Turalio CAPS 125MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Tenosynovial Giant Cell Tumor (TGCT): Diagnosis of TGCT. Patient is symptomatic. Patient is not a candidate for surgery due to worsening functional limitation or severe morbidity with surgical removal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TYENNE SC

Products Affected

- Tyenne INJ 162MG/0.9ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: 1) Trial, contraindication, or intolerance (T/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Rinvoq (upadacitinib), or tofacitinib, OR 2) for continuation of prior therapy if within the past 120 days. Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: 1) T/C/I to two of the following: Enbrel (etanercept), one formulary adalimumab product, Rinvoq/Rinvoq LQ, tofacitinib, OR 2) for continuation of prior therapy if within the past 120 days. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA.
Age Restrictions	N/A
Prescriber Restrictions	RA, SJIA, PJIA, GCA (Initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	RA, SJIA, PJIA, GCA (Initial, Reauth): Plan year
Other Criteria	RA, SJIA, PJIA, GCA (reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL): Both of the following: 1) diagnosis of Stage IA MF-CTCL OR diagnosis of Stage IB MF-CTCL AND 2) patient has received at least one prior skin-directed therapy (e.g., topical corticosteroids [e.g., clobetasol propionate, fluocinonide], bexarotene topical gel [Targretin topical gel], etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VALTOCO

Products Affected

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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epilepsy: Diagnosis of epilepsy. Frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VANDETANIB

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Thyroid Cancer: Diagnosis of medullary thyroid cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VANFLYTA

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is FLT3 internal tandem duplication (ITD) positive. Vanflyta will be used in combination with standard cytarabine and anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VAXCHORA

Products Affected

- Vaxchora

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Vaccine is being used for active immunization against disease caused by Vibrio cholerae serogroup O1. Patient is traveling to a cholera-affected area. Age 2 through 64 years.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VELSIPITY

Products Affected

- Velsipity

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL): Diagnosis of CLL or SLL. Acute Myeloid Leukemia (AML): One of the following: 1) Diagnosis of newly diagnosed AML AND Used in combination with one of the following: azacitidine, decitabine, cladribine, fludarabine, idarubicin, or cytarabine, AND One of the following: a) used as treatment for induction therapy, b) used as follow-up after induction therapy, or c) used as consolidation therapy as continuation of lower-intensity regimen used for induction, 2) Diagnosis of relapsed/refractory acute myeloid leukemia (AML) AND Used in combination with one of the following: cladribine, cytarabine, decitabine, fludarabine, or idarubicin, or 3) Diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) - acute myeloid leukemia (AML) AND Used in combination with azactidine or decitabine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VERQUVO

Products Affected

- Verquvo

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Advanced, Recurrent, or Metastatic Breast Cancer: Diagnosis of advanced, recurrent, or metastatic breast cancer. Disease is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane), OR b) used in combination with Faslodex (fulvestrant) OR c) used as monotherapy and disease has progressed following endocrine therapy and patient has already received at least one prior chemotherapy regimen. Early Breast Cancer: Diagnosis of early breast cancer at high risk of recurrence. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Used in combination with one of the following endocrine therapies: 1) tamoxifen or 2) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIGABATRIN

Products Affected

- Vigabatrin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Complex Partial Seizures (CPS): For use as adjunctive therapy. Trial, contraindication, or intolerance (T/C/I) to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]. Infantile Spasms (IS): Diagnosis of infantile spasms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIGAFYDE

Products Affected

- Vigafyde

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of infantile spasms. Trial or intolerance to generic vigabatrin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VILAZODONE TABLET

Products Affected

- Vilazodone Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of major depressive disorder (MDD). Trial, contraindication, or intolerance to one formulary selective serotonin reuptake inhibitor/serotonin norephinephrine reuptake inhibitor (SSRI/SNRI) indicated for MDD (e.g., sertraline tablet, escitalopram, venlafaxine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year.
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: A) Both of the following: 1) Patient has been diagnosed with one of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, or c) Post-essential thrombocythemia myelofibrosis, and 2) One of the following: a) Both of the following: i) Patient has symptomatic lower-risk myelofibrosis, and ii) Patient has a platelet count below 50 x 10^9/L, or b) One of the following: i) Patient has both of the following: higher-risk myelofibrosis AND a platelet count below 50 x 10^9/L, or ii) Patient has all of the following: higher-risk myelofibrosis, AND symptomatic splenomegaly and/or constitutional symptoms, AND a platelet count greater than or equal to 50 x 10^9/L, OR B) Used for treatment of myelofibrosis-associated anemia, OR C) Both of the following: 1) Diagnosis of accelerated/blast phase myeloproliferative neoplasm, and 2) Used for splenomegaly and other disease-related symptoms in one of the following: a) Continued near the start of conditioning therapy of transplant candidates, or b) Palliation in combination with hypomethylating agents (e.g., azacitidine or decitabine) as bridging therapy prior to transplant, or if not a candidate for transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VORANIGO

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Astrocytoma or Oligodendroglioma. Presence of an isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation. History of one of the following: a) Biopsy, b) Sub-total resection, or c) Gross total resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VORICONAZOLE INJECTION

Products Affected

- Voriconazole INJ 200MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Invasive aspergillosis: Diagnosis of invasive aspergillosis (IA). Candidemia: Diagnosis of candidemia. One of the following: (1) patient is non-neutropenic or (2) infection is located in skin, abdomen, kidney, bladder wall, or wounds. Esophageal Candidiasis: Diagnosis of esophageal candidiasis. Mycosis: Diagnosis of fungal infection caused by Scedosporium apiospermum (asexual form of Pseudallescheria boydii) or Fusarium spp. including Fusarium solani. For fusariosis: Patient is intolerant of, or refractory to, other therapy (e.g., liposomal amphotericin B, amphotericin B lipid complex).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and patient is not receiving Vosevi in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOTRIENT

Products Affected

- Pazopanib Hydrochloride TABS 200MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal Cell Carcinoma (RCC): Diagnosis of RCC. Soft tissue sarcoma (STS): Diagnosis of advanced STS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOWST

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of recurrent clostridioides difficile infection (CDI) as defined by both of the following: 1) Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for two consecutive days, and 2) A positive stool test for C.difficile toxin or toxigenic C.difficile. Patient has a history of one or more recurrent episodes of CDI within 12 months. All of the following: 1) Patient has completed at least 10 consecutive days of one of the following antibiotic therapies 2-4 days prior to initiating Vowst: oral vancomycin or Dificid (fidaxomicin), 2) Patient has completed or is planning to complete the recommended course of magnesium citrate the day before and at least 8 hours prior to initiating Vowst, and 3) Previous episode of CDI is under control (e.g., less than 3 unformed/loose [i.e., Bristol Stool Scale type 6-7] stools/day for 2 consecutive days).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist or infectious disease specialist.
Coverage Duration	14 days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VYVGART

Products Affected

- Vyvgart Hytrulo INJ 1000MG/5ML; 10000UNIT/5ML

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

WEGOVY

Products Affected

- Wegovy INJ

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

WEGOVY TABLET

Products Affected

- Wegovy TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

WINREVAIR

Products Affected

- Winrevair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosis of PAH. PAH is symptomatic. Patient is currently on at least two therapies indicated for the treatment of PAH from the following different mechanisms of action, unless there is a contraindication or intolerance: a) Endothelin receptor antagonists (i.e., Bosentan, ambrisentan or macitentan) and b) Phosphodiesterase 5 inhibitors (i.e., Tadalafil or sildenafil).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Plan Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Anaplastic Large Cell Lymphoma (ALCL): Diagnosis of systemic ALCL. Disease is relapsed or refractory. Tumor is anaplastic lymphoma kinase (ALK)-positive. Inflammatory Myofibroblastic Tumor (IMT): Diagnosis of IMT. Tumor is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XATMEP

Products Affected

- Xatmep

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of carcinoid syndrome diarrhea. Diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g., octreotide, lanreotide) for at least 3 months. Used in combination with SSA therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist.
Coverage Duration	Initial: 6 months, Reauth: plan year.
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy. Will continue to be used in combination with SSA therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XIFAXAN

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

XOLREMDI

Products Affected

- Xolremdi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome. Patient has genotype confirmed variant of CXCR4. Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells/microLiter.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with one of the following: dermatologist, immunologist, hematologist, geneticist, or allergist.
Coverage Duration	Initial: 6 months, Reauth: Plan Year
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acute myeloid leukemia (AML). AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive. One of the following: a) Used as low-intensity treatment induction when not a candidate for intensive induction therapy, b) Follow-up after induction therapy with response to previous lower intensity therapy with the same regimen, c) Post-allogeneic hematopoietic cell transplantation and in remission, d) Disease is relapsed or refractory, or e) Consolidation therapy as continuation of low-intensity regimen used for induction in patients with poor-risk AML.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XPOVIO

Products Affected

- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma (MM): Diagnosis of multiple myeloma. Patient has received at least one prior therapy (e.g., lenalidomide, bortezomib, daratumumab, pomalidomide). Used in combination with one of the following: bortezomib and dexamethasone, daratumumab and dexamethasone, or carfilzomib and dexamethasone. Relapsed/Refractory Multiple Myeloma (RRMM): Diagnosis of relapsed or refractory multiple myeloma (RRMM). Patient has received at least four prior therapies (e.g., lenalidomide, bortezomib, daratumumab, pomalidomide). Disease is refractory to all of the following: 1) Two proteasome inhibitors (e.g., bortezomib, carfilzomib), 2) Two immunomodulatory agents (e.g., lenalidomide, thalidomide), and 3) An anti-CD38 monoclonal antibody (e.g. daratumumab). Used in combination with dexamethasone. Diffuse large B-cell lymphoma (DLBCL): Diagnosis of one of the following: 1) Relapsed or refractory DLBCL not otherwise specified OR 2) Relapsed or refractory DLBCL arising from follicular lymphoma. Patient has previously received at least two lines of systemic therapy (e.g., CHOP: cyclophosphamide, doxorubicin, vincristine, and prednisone plus rituximab).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prostate cancer (PC): Diagnosis of prostate cancer. One of the following: 1) Disease is castration-resistant, 2) Disease is both of the following: a) Metastatic, and b) Castration-sensitive, or 3) Disease is all of the following: a) Non-metastatic, b) Castration-sensitive, c) Recurrent, and d) High risk of metastasis. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] or 2) Patient has had bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

YESINTEK

Products Affected

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

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZEJULA

Products Affected

- Zejula TABS

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Patient is positive for BRAF V600 mutation. Erdheim-Chester Disease: Diagnosis of Erdheim-Chester disease AND Disease is BRAFV600 mutant type (MT).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZENBEXUS

Products Affected

- Zenbexus

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

ZOKINVY

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	One of the following: 1) Diagnosis of Hutchinson-Gilford Progeria Syndrome, OR 2) For treatment of processing-deficient Progeroid Laminopathies with one of the following: i) Heterozygous LMNA mutation with progerin-like protein accumulation OR ii) Homozygous or compound heterozygous ZMPSTE24 mutations. Patient has a body surface area of 0.39 m^2 and above.
Age Restrictions	Patient is 12 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Patient has progressive, persistent, or recurrent disease on or following two systemic therapies [e.g., Adcetris (brentuximab vedotin), bexarotene, interferon gamma-1b, methotrexate, Poteligeo (mogamulizumab), romidepsin].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZORYVE

Products Affected

- Zoryve CREA

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Zoryve 0.3% Plaque psoriasis (PsO) (Initial): Diagnosis of PsO. Minimum duration of a 4-week trial, contraindication, or intolerance to one of the following topical therapies: corticosteroids (e.g., betamethasone, clobetasol), vitamin D analogs (e.g., calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (e.g., tacrolimus, pimecrolimus), vitamin D analog/corticosteroid (e.g., Enstilar, Taclonex) or Duobrii (halobetasol/tazarotene). Zoryve 0.05%, 0.15% Atopic dermatitis (AD) (Initial): Diagnosis of mild to moderate AD. Trial of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following: medium or higher potency topical corticosteroid, pimecrolimus cream, or tacrolimus ointment.
Age Restrictions	N/A
Prescriber Restrictions	PsO (Initial): Prescribed by or in consultation with a dermatologist. AD (Initial): Prescribed by or in consultation with a dermatologist or allergist/immunologist.
Coverage Duration	PsO, AD (Initial, Reauth): Plan Year.
Other Criteria	PsO, AD (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZORYVE FOAM

Products Affected

- Zoryve FOAM

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Seborrheic Dermatitis (SD) (Initial): Diagnosis of SD. Minimum duration of a 4-week trial, contraindication, or intolerance (T/C/I) to one of the following generic topical therapies: corticosteroids (eg, betamethasone, clobetasol), antifungals (eg, ciclopirox, ketoconazole), or calcineurin inhibitors (eg, tacrolimus). Plaque Psoriasis (PsO) (Initial): Diagnosis of plaque psoriasis. Minimum duration of a 4-week T/C/I to one of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), or one of the following topical combination therapies: vitamin D analog/corticosteroid (eg, Enstilar, Taclonex) or Duobrii (halobetasol/tazarotene).
Age Restrictions	N/A
Prescriber Restrictions	SD, PsO (Initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	SD, PsO: Plan Year.
Other Criteria	SD, PsO (Reauth): Patient demonstrates positive clinical response to therapy.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZTALMY

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD). Patient has a mutation in the CDKL5 gene.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Plan Year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZURZUVAE

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postpartum Depression (PPD): Diagnosis of PPD. Onset of symptoms in the third trimester or within 4 weeks of delivery. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae.
Age Restrictions	PPD: Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYKADIA

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic, recurrent, or advanced non-small cell lung cancer (NSCLC), tumor is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYMFENTRA

Products Affected

- Zymfentra 2-pen
- Zymfentra 2-syringe

PA Criteria	Criteria Details
Indications	Pending CMS Review
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Prerequisite Therapy Required	Pending CMS Review

PART B VERSUS PART D

Products Affected

- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Arformoterol Tartrate
- Astagraf XL
- Azathioprine TABS 50MG
- Budesonide SUSP
- Calcitriol CAPS
- Calcitriol ORAL SOLN
- Calcium Acetate CAPS
- Calcium Acetate TABS 667MG
- Cinacalcet Hydrochloride
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS 50MG
- Cyclosporine CAPS
- Cyclosporine Modified
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Gengraf CAPS 100MG, 25MG
- Granisetron Hydrochloride TABS
- Heparin Sodium INJ 10000UNIT/ML, 1000UNIT/ML, 20000UNIT/ML, 5000UNIT/ML
- Heplisav-b
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU 0.31MG/3ML, 1.25MG/3ML
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Nutrilipid
- Ondansetron Hcl SOLN 4MG/5ML
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- Paricalcitol CAPS
- Pentamidine Isethionate INHALATION SOLR
- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sevelamer Carbonate
- Sirolimus SOLN
- Sirolimus TABS

- Tacrolimus CAPS
- Tobramycin NEBU 300MG/5ML
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML

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.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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