

You can contact Humana for the most recent list of drugs by calling the number on the back of your membership card, or for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m., Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week, by visiting Humana.com.

Prior Authorization Criteria

Effective 04/01/2026

ABILIFY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ABILIFY MYCITE MAINTENANCE KIT - TABLET WITH SENSOR AND STRIP

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia, Schizoaffective Disorder, or Bipolar I Disorder: The member must have one of the following clinically diagnosed conditions: Schizophrenia (acute/maintenance), Schizoaffective Disorder OR Bipolar I Disorder AND the member must have documentation of prior therapy, intolerance, or contraindication to aripiprazole and at least one of the following: risperidone, olanzapine, quetiapine, ziprasidone, or lurasidone. The member must have documentation of previous non-adherence that has led to failure to meet treatment goals. Major depressive disorder: The member must have clinically diagnosed major depressive disorder AND the member must have had prior therapy, intolerance, or contraindication to aripiprazole AND at least one product considered antidepressant therapies (ADT) AND Abilify MyCite must be used as adjunctive or add-on treatment to ADT and not as monotherapy. The member must have documentation of previous non-adherence that has led to failure to meet treatment goals.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ABILIFY MYCITE STARTER KIT - TABLET WITH SENSOR, STRIP, AND POD

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia, Schizoaffective Disorder, or Bipolar I Disorder: The member must have one of the following clinically diagnosed conditions: Schizophrenia (acute/maintenance), Schizoaffective Disorder OR Bipolar I Disorder AND the member must have documentation of prior therapy, intolerance, or contraindication to aripiprazole and at least one of the following: risperidone, olanzapine, quetiapine, ziprasidone, or lurasidone. The member must have documentation of previous non-adherence that has led to failure to meet treatment goals. Major depressive disorder: The member must have clinically diagnosed major depressive disorder AND the member must have had prior therapy, intolerance, or contraindication to aripiprazole AND at least one product considered antidepressant therapies (ADT) AND Abilify MyCite must be used as adjunctive or add-on treatment to ADT and not as monotherapy. The member must have documentation of previous non-adherence that has led to failure to meet treatment goals.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

abiraterone - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Prostate Cancer: Members with severe hepatic impairment (Child-Pugh Class C).
Required Medical Information	For brand Zytiga requests: Member must have an intolerance or contraindication to generic abiraterone acetate AND member must meet clinical criteria below. Prostate Cancer: One of the following applies: The member has metastatic castration-resistant prostate cancer (mCRPC) or The member has a diagnosis of castration-sensitive prostate cancer (CSPC) and The member will be using Zytiga (abiraterone acetate) in combination with a corticosteroid (prednisone, dexamethasone) and the member will use Zytiga (abiraterone acetate) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

abirtega - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Prostate Cancer: Members with severe hepatic impairment (Child-Pugh Class C).
Required Medical Information	For brand Zytiga requests: Member must have an intolerance or contraindication to generic abiraterone acetate AND member must meet clinical criteria below. Prostate Cancer: One of the following applies: The member has metastatic castration-resistant prostate cancer (mCRPC) or The member has a diagnosis of castration-sensitive prostate cancer (CSPC) and The member will be using Zytiga (abiraterone acetate) in combination with a corticosteroid (prednisone, dexamethasone) and the member will use Zytiga (abiraterone acetate) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ABRAXANE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Breast Cancer. The member has a diagnosis of metastatic (Stage IV) or recurrent breast cancer. The member received prior therapy that included an anthracycline (e.g. doxorubicin, epirubicin). The member has documented hypersensitivity reaction to conventional paclitaxel or docetaxel or the member has a documented contraindication to standard hypersensitivity premedications. Non-small Cell Lung Cancer (NSCLC) [Squamous Cell Histology]. The member has a diagnosis of locally advanced, recurrent or metastatic NSCLC. Member has documented hypersensitivity reaction to conventional paclitaxel or docetaxel or the member has a documented contraindication to standard hypersensitivity premedications AND member has squamous histology where nab-paclitaxel will be given in combo with Keytruda (pembrolizumab) and carboplatin as first line therapy. Non-small Cell Lung Cancer (NSCLC). The member has a diagnosis of locally advanced, recurrent or metastatic NSCLC. One of the following applies: The member will be using nab-paclitaxel as monotherapy or in combination with carboplatin AND One of the following apply: will be using for first line therapy OR member will be using as subsequent therapy AND The member has documented hypersensitivity reaction to conventional paclitaxel or docetaxel or the member has a documented contraindication to standard hypersensitivity premedications OR member has metastatic NSCLC, non- squamous histology with no EGFR or ALK genomic tumor aberrations AND nab-paclitaxel will be given combo with Tecentriq (atezolizumab) and carboplatin as first line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration

ABRAXANE - VIAL (EA)

Other Criteria	Ovarian Cancer. The member has a diagnosis of epithelial ovarian cancer, fallopian tube cancer or primary peritoneal cancer. The member meets one of the following criteria: Progressive, stable or persistent disease on primary chemotherapy OR Recurrent disease. The member has documented hypersensitivity reaction to conventional paclitaxel or docetaxol or the member has a documented contraindication to standard hypersensitivity premedications. Pancreatic Cancer: The member has a diagnosis of pancreatic cancer and nab-paclitaxel is being used in combination with gemcitabine as neoadjuvant therapy or The member has a diagnosis of metastatic pancreatic cancer AND The member will be using nab-paclitaxel in combination with gemcitabine. Melanoma: The member has a diagnosis of unresectable or metastatic melanoma AND The member will be using nab-paclitaxel as second-line or subsequent therapy after progression on prior therapy AND The member has documented hypersensitivity reaction to conventional paclitaxel or docetaxol or the member has a documented contraindication to standard hypersensitivity premedications.
Part B Prerequisite	0

ABRILADA(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ABRILADA(CF) - SYRINGE KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ABRILADA(CF) PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ABRILADA(CF) PEN - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ACCOLATE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ACIPHEX - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

acitretin - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a diagnosis of severe cutaneous psoriasis including plaque, guttate, erythrodermic, palmar-plantar, and pustular types AND the member has had previous treatment, contraindication, or intolerance to methotrexate or cyclosporine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ACTEMRA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderately to Severely Active Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Systemic Juvenile Idiopathic Arthritis: The member must have a diagnosis of active systemic juvenile idiopathic arthritis (SJIA) or as formerly known, systemic juvenile rheumatoid arthritis. Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): The member has a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) confirmed by the following criteria: High Resolution Computer Tomography (HRCT) OR Lung Biopsy. Actemra (tocilizumab) is prescribed by, or in consultation with, a specialist (e.g. a rheumatologist) with experience in the treatment of SSc-ILD. The member has had prior therapy, contraindication, or intolerance with mycophenolate mofetil. Giant Cell Arteritis: The member must have a diagnosis of giant cell arteritis AND the member must have tried or cannot use Tyenne AND Rinvoq.
Age Restriction	Member must be 18 years and older. For the treatment of PJIA and SJIA the member must be at least 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ACTEMRA ACTPEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderately to Severely Active Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Systemic Juvenile Idiopathic Arthritis: The member must have a diagnosis of active systemic juvenile idiopathic arthritis (SJIA) or as formerly known, systemic juvenile rheumatoid arthritis. Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): The member has a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) confirmed by the following criteria: High Resolution Computer Tomography (HRCT) OR Lung Biopsy. Actemra (tocilizumab) is prescribed by, or in consultation with, a specialist (e.g. a rheumatologist) with experience in the treatment of SSc-ILD. The member has had prior therapy, contraindication, or intolerance with mycophenolate mofetil. Giant Cell Arteritis: The member must have a diagnosis of giant cell arteritis AND the member must have tried or cannot use Tyenne AND Rinvoq.
Age Restriction	Member must be 18 years and older. For the treatment of PJIA and SJIA the member must be at least 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ACTHAR - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	West syndrome (infantile spasms): Member has a diagnosis of West Syndrome (infantile spasms) AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of West Syndrome (e.g., neurologist, epileptologist). Acute exacerbation of multiple sclerosis (MS): The member is experiencing an acute exacerbation of multiple sclerosis (MS) AND The member is currently taking a disease-modifying treatment (DMT) for MS (e.g., dimethyl fumarate, fingolimod, teriflunomide, a glatiramer product, etc.) unless at least one of the following applies: This is the member's first clinical episode of MS (i.e., clinically isolated syndrome [CIS]), The provider attests that use of any disease-modifying treatment for MS is inappropriate for the individual member AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of multiple sclerosis (e.g., neurologist) AND One of the following applies: The member has failed a recent (within the last 30 days) trial of at least a 3-day course of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone) for an acute exacerbation of MS. Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects.
Age Restriction	West syndrome (infantile spasms): Member is less than 2 years old.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ACTHAR - VIAL (ML)

Other Criteria	Acute exacerbation of rheumatic disorders, collagen diseases, ophthalmic diseases, nephrotic syndrome or other steroid-responsive conditions: The member is experiencing an acute exacerbation of one of the following: A rheumatic disorder (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis) OR A collagen disease (e.g., systemic lupus erythematosus, systematic dermatomyositis) OR An ophthalmic disease (e.g., keratitis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation) OR Nephrotic syndrome OR Other steroid-responsive condition AND One of the following applies: The member has failed a trial of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone) for their condition. Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects. Symptomatic sarcoidosis: The member has a diagnosis of sarcoidosis AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of sarcoidosis (e.g., rheumatologist, pulmonologist, cardiologist) AND One of the following applies: The member has failed a trial of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone). Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The member has tried at least one other medication, either in combination with or as an alternative to corticosteroids, for the treatment of sarcoidosis (e.g., methotrexate, azathioprine, infliximab, adalimumab) AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects.
Part B Prerequisite	0

ACTHAR SELFJECT - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	West syndrome (infantile spasms): Member has a diagnosis of West Syndrome (infantile spasms) AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of West Syndrome (e.g., neurologist, epileptologist). Acute exacerbation of multiple sclerosis (MS): The member is experiencing an acute exacerbation of multiple sclerosis (MS) AND The member is currently taking a disease-modifying treatment (DMT) for MS (e.g., dimethyl fumarate, fingolimod, teriflunomide, a glatiramer product, etc.) unless at least one of the following applies: This is the member's first clinical episode of MS (i.e., clinically isolated syndrome [CIS]), The provider attests that use of any disease-modifying treatment for MS is inappropriate for the individual member AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of multiple sclerosis (e.g., neurologist) AND One of the following applies: The member has failed a recent (within the last 30 days) trial of at least a 3-day course of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone) for an acute exacerbation of MS. Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects.
Age Restriction	West syndrome (infantile spasms): Member is less than 2 years old.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ACTHAR SELFJECT - PEN INJECTOR (ML)

Other Criteria	Acute exacerbation of rheumatic disorders, collagen diseases, ophthalmic diseases, nephrotic syndrome or other steroid-responsive conditions: The member is experiencing an acute exacerbation of one of the following: A rheumatic disorder (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis) OR A collagen disease (e.g., systemic lupus erythematosus, systematic dermatomyositis) OR An ophthalmic disease (e.g., keratitis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation) OR Nephrotic syndrome OR Other steroid-responsive condition AND One of the following applies: The member has failed a trial of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone) for their condition. Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects. Symptomatic sarcoidosis: The member has a diagnosis of sarcoidosis AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of sarcoidosis (e.g., rheumatologist, pulmonologist, cardiologist) AND One of the following applies: The member has failed a trial of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone). Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The member has tried at least one other medication, either in combination with or as an alternative to corticosteroids, for the treatment of sarcoidosis (e.g., methotrexate, azathioprine, infliximab, adalimumab) AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects.
Part B Prerequisite	0

ACTIMMUNE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Granulomatous Disease (CGD): The member has chronic granulomatous disease (CGD). The member is using Actimmune to reduce the frequency and severity of infections. Severe Malignant Osteopetrosis: The member has severe malignant osteopetrosis. The member is using Actimmune to delay time to disease progression.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ACTONEL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ACTOPLUS MET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ACTOS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

acyclovir - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Recurrent herpes labialis (cold sores): Member has a diagnosis of recurrent herpes labialis (cold sores) AND the member has had previous treatment, contraindication, or intolerance with oral acyclovir and valacyclovir.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

acyclovir - OINTMENT (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must have a diagnosis of genital herpes OR member has a diagnosis of non-life-threatening mucocutaneous Herpes Simplex Virus (HSV) infection and is immunocompromised. The member has had previous treatment, contraindication, or intolerance with oral acyclovir and valacyclovir.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ADAKVEO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Sickle Cell Disease: Has a diagnosis of sickle cell disease AND Has experienced 2 or more sickle cell crises (i.e., medical facility visit for sickle cell-related pain, acute chest syndrome, priapism, or hepatic/splenic sequestration) in the previous 12 months AND Has had previous treatment, intolerance, or contraindication with both hydroxyurea capsule AND L-glutamine oral packet (generic for Endari) AND Is not receiving concomitant chronic, prophylactic blood transfusion therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ADALIMUMAB-AACF - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-AACF - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ADALIMUMAB-AACF(CF) PEN CROHNS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-AACF(CF) PEN CROHNS - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ADALIMUMAB-AACF(CF) PEN PS-UV - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-AACF(CF) PEN PS-UV - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ADALIMUMAB-AATY - AUTO-INJECTOR, KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-AATY - AUTO-INJECTOR, KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ADALIMUMAB-AATY(CF) AI CROHNS - AUTO-INJECTOR, KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-AATY(CF) AI CROHNS - AUTO-INJECTOR, KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ADALIMUMAB-ADAZ - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-ADAZ - PEN INJECTOR (ML)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

ADALIMUMAB-ADBM - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-ADBM - PEN INJECTOR KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

ADALIMUMAB-ADBM(CF) PEN CROHNS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-ADBM(CF) PEN CROHNS - PEN INJECTOR KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

ADALIMUMAB-ADBM(CF) PEN PS-UV - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-ADBM(CF) PEN PS-UV - PEN INJECTOR KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

ADALIMUMAB-BWWD - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-BWWD - SYRINGE (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ADALIMUMAB-FKJP - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-FKJP - SYRINGE KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ADALIMUMAB-RYVK - AUTO-INJECTOR, KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ADALIMUMAB-RYVK - AUTO-INJECTOR, KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

ADBRY - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: The member has a diagnosis of moderate to severe Atopic Dermatitis (e.g. erythema that is pink-red to deep or bright red, moderate to severe induration/papulation, frequent to incessant itching, frequent to nightly loss of sleep) AND The member has had previous treatment with, intolerance or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/ointment, triamcinolone acetonide 0.5%) OR one topical calcineurin inhibitor (e.g. tacrolimus ointment) AND the member has had previous treatment with, intolerance or contraindication to Dupixent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ADCETRIS - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	For Hodgkin lymphoma (relapsed or refractory), Hodgkin Lymphoma Post-auto-HSCT Consolidation, Large B-Cell Lymphoma (LBCL), Systemic Anaplastic Large Cell Lymphoma (sALCL) (relapsed or refractory), Primary Cutaneous Anaplastic Large Cell Lymphoma (pcALCL) or CD30-expressing Mycosis Fungoides (MF): Members that have experienced disease progression while on Adcetris.
Required Medical Information	Hodgkin lymphoma. Diagnosis of relapsed or refractory Hodgkin lymphoma. The member has documented evidence of progression following an autologous stem cell transplant OR is not a candidate for an autologous stem cell transplant but documented evidence of progression on at least two previous multi-agent chemotherapy regimens OR the member will be using Adcetris (brentuximab) as palliative therapy for older adults (age greater than 60). The member will be using Adcetris as monotherapy or in combination with bendamustine. Systemic Anaplastic Large Cell Lymphoma (sALCL). Diagnosis of relapsed or refractory systemic anaplastic large cell lymphoma. The member has documented evidence of progression on at least one prior multi-agent chemotherapy regimen The member will be using Adcetris (brentuximab vedotin) as monotherapy. Disease has confirmed CD30 positivity. Hodgkin Lymphoma Post-auto-HSCT Consolidation: The member has a diagnosis of classical Hodgkin lymphoma AND The member will be using Adcetris (brentuximab vedotin) as post-autologous hematopoietic stem cell transplant (HSCT) consolidation AND The member is at high risk of post-autologous HSCT relapse or progression (must meet at least one of the following criteria): Refractory disease to front-line therapy, Relapsed disease within 12 months to front-line therapy, Relapsed disease with extranodal disease to front-line therapy. Previously untreated Hodgkin lymphoma. The member has a diagnosis of stage III or IV classical Hodgkin lymphoma AND The member has previously untreated disease AND The member will be using Adcetris (brentuximab vedotin) in combination with doxorubicin, vinblastine, and dacarbazine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

ADCETRIS - VIAL (EA)

Other Criteria	Primary Cutaneous Anaplastic Large Cell Lymphoma (pcALCL) or CD30-expressing Mycosis Fungoides (MF). The member has a diagnosis of primary cutaneous anaplastic large cell lymphoma (pcALCL) or CD30-expressing mycosis fungoides (MF) AND The member has received at least one prior systemic therapy AND The member will be using Adcetris (brentuximab vedotin) as monotherapy. Large B-cell Lymphoma (LBCL): The member has a diagnosis of relapsed or refractory LBCL, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from indolent lymphoma, or high-grade B-cell lymphoma (HGBL) AND The member has received 2 or more lines of prior systemic therapy AND The member is ineligible for autologous hematopoietic stem cell transplantation or chimeric antigen receptor (CAR) T-cell therapy AND Adcetris (brentuximab vedotin) will be used in combination with lenalidomide and a rituximab product.
Part B Prerequisite	0

ADCIRCA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. The member must have had prior therapy, intolerance or contraindication to sildenafil (generic Revatio) or tadalafil (generic Adcirca) for the treatment of PAH (WHO Group I).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ADDERALL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ADDERALL XR - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ADEMPAS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Thromboembolic Pulmonary Hypertension (CTEPH). The member must have a diagnosis of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) AND The member must have CTEPH classified as inoperable or persistent/recurrent after surgical treatment (i.e. pulmonary endarterectomy). Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ADSTILADRIN - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on Adstiladrin (nadofaragene firadenovec-vncg)
Required Medical Information	Non-muscle invasive bladder cancer (NMIBC): Member has a diagnosis of high-risk Bacillus Calmette-Guerin (BCG)-unresponsive disease, which is defined as persistent or recurrent disease following adequate BCG therapy (adequate BCG is defined as the administration of at least five of six doses of an initial induction course plus either of: at least two of three doses of maintenance therapy or at least two of six doses of a second induction course) AND member has non-muscle invasive bladder cancer (NMIBC) with documented carcinoma in situ (CIS) AND member is ineligible for or has elected not to undergo cystectomy.
Age Restriction	Member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

ADVAIR DISKUS - BLISTER, WITH INHALATION DEVICE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ADZYNMA - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Congenital thrombotic thrombocytopenic purpura (cTTP): The member has a diagnosis of congenital thrombotic thrombocytopenic purpura (cTTP) defined as all of the following: ADAMTS13 activity less than 10% of normal AND Molecular genetic testing indicates presence of ADAMTS13 mutation AND Member does not have ADAMTS13 auto-antibodies AND Adzynma is prescribed by or in consultation with a hematologist or specialist in genetic hematological diseases.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AEMCOLO - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Traveler's diarrhea: Member must have traveler's diarrhea caused by non-invasive strains of Escherichia Coli AND Member's condition is not complicated by fever or blood in the stool AND Member has tried or cannot use ciprofloxacin, levofloxacin, or azithromycin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AFINITOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on everolimus.
Required Medical Information	For brand Afinitor requests: Member must have an intolerance or contraindication to generic everolimus AND member must meet clinical criteria below. Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV). Subependymal Giant Cell Astrocytoma (SEGA) with TSC [Adult and Pediatrics]. The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestinal or lung.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Angiomyolipoma and Tuberous Sclerosis Complex (TSC). The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor (HR)positive and human epidermal growth factor receptor 2 (HER2) negative advanced or metastatic disease AND the member has been treated with endocrine therapy (e.g. letrozole, anastrozole) AND The member will use everolimus in combination with exemestane or fulvestrant. Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC- associated partial onset seizures AND everolimus tablets for oral suspension is being used as adjunctive therapy.
Part B Prerequisite	0

AFINITOR DISPERZ - TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on everolimus.
Required Medical Information	For brand Afinitor requests: Member must have an intolerance or contraindication to generic everolimus AND member must meet clinical criteria below. Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV). Subependymal Giant Cell Astrocytoma (SEGA) with TSC [Adult and Pediatrics]. The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestinal or lung.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Angiomyolipoma and Tuberous Sclerosis Complex (TSC). The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor (HR)positive and human epidermal growth factor receptor 2 (HER2) negative advanced or metastatic disease AND the member has been treated with endocrine therapy (e.g. letrozole, anastrozole) AND The member will use everolimus in combination with exemestane or fulvestrant. Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC- associated partial onset seizures AND everolimus tablets for oral suspension is being used as adjunctive therapy.
Part B Prerequisite	0

AFREZZA - CARTRIDGE WITH INHALER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member does not have chronic lung disease such as asthma or chronic obstructive pulmonary disease (COPD).
Required Medical Information	Type 1 diabetes mellitus: Diagnosis of type 1 diabetes mellitus AND Member has had previous treatment with a meal-time (i.e. prandial) insulin administered by subcutaneous injection (i.e. preparations containing insulin lispro, insulin aspart, insulin glulisine, or regular insulin)AND Member has not achieved goal HbA1c after at least 90 days of treatment with injectable meal-time insulin AND Member will be using Afrezza with a long-acting insulin (i.e. insulin glargine, insulin detemir, insulin degludec, insulin isophane)AND Member does not smoke. Type 2 diabetes mellitus: Diagnosis of type 2 diabetes mellitus AND Member has had previous treatment, contraindication, or intolerance with a metformin containing medicine AND Member has had previous treatment with a meal-time (i.e. prandial) insulin administered by subcutaneous injection (i.e. preparations containing insulin lispro, insulin aspart, insulin glulisine, or regular insulin)AND Member has not achieved goal HbA1c after at least 90 days of treatment with metformin and injectable meal-time insulin AND Member does not smoke.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AGAMREE - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Duchenne Muscular Dystrophy: The member has a diagnosis of Duchenne Muscular Dystrophy (DMD) confirmed by dystrophin genetic testing AND Agamree (vamorolone) is prescribed by or in consultation with a provider experienced in the management of DMD (e.g., neurologist, neuromuscular specialist) AND The member is ambulatory (i.e., able to walk independently or with assistance) when Agamree (vamorolone) therapy is started AND The member has had previous treatment with prednisone for at least 6 months and experienced ONE of the following: Clinically significant reduction in growth trajectory (i.e., decline in height percentile) as determined by the provider OR A severe behavioral adverse effect (e.g., unmanageable irritation, aggression) that required prednisone dose reduction.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AGRYLIN - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AIMOVIG AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention. Will be utilizing Aimovig (erenumab) for the preventative treatment of migraines AND has had previous treatment with Emgality AND Qulipta.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AJOVY AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention. Will be utilizing Ajovy (fremanezumab) for the preventative treatment of migraines AND has had previous treatment with Emgality AND Qulipta.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

AJOVY SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention. Will be utilizing Ajoy (fremanezumab) for the preventative treatment of migraines AND has had previous treatment with Emgality AND Qulipta.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

AKEEGA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].
Required Medical Information	Metastatic Castration-Resistant Prostate Cancer: Member has a diagnosis metastatic castration-resistant prostate cancer (mCRPC) AND Member has documented deleterious or suspected deleterious BRCA-mutated (BRCAm) disease AND Member will use in combination with prednisone or prednisolone AND Member will use Akeega (niraparib and abiraterone acetate) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]). Metastatic Castration-Sensitive Prostate Cancer: Member has a diagnosis metastatic castration-sensitive prostate cancer (mCSPC) AND Member has documented deleterious or suspected deleterious BRCA-mutated (BRCAm) disease AND Member will use in combination with prednisone or prednisolone AND Member will use Akeega (niraparib and abiraterone acetate) in combination with androgen deprivation therapy (e.g., previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AKYNZEO (FOSNETUPITANT) - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of chemotherapy-induced nausea and vomiting: Member has failed to achieve control of nausea and/or vomiting with aprepitant capsule at the FDA indicated dose OR has a contraindication to aprepitant capsule OR has experienced significant side effects on aprepitant capsule necessitating alternative therapies AND Will be used in conjunction with highly emetogenic cancer chemotherapy (HEC) or moderately emetogenic cancer chemotherapy (MEC). BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AKYNZEO (NETUPITANT) - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of chemotherapy-induced nausea and vomiting: Member has failed to achieve control of nausea and/or vomiting with aprepitant capsule at the FDA indicated dose OR has a contraindication to aprepitant capsule OR has experienced significant side effects on aprepitant capsule necessitating alternative therapies AND Will be used in conjunction with highly emetogenic cancer chemotherapy (HEC) or moderately emetogenic cancer chemotherapy (MEC). BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ALDURAZYME - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Mucopolysaccharidosis 1 (MPS 1).The member must have a diagnosis of: Hurler or Hurler-Scheie forms of MPS 1, OR Scheie form of MPS 1 with moderate to severe symptoms.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year
Other Criteria	NA
Part B Prerequisite	0

ALECENSA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Non-Small Cell Lung Cancer (Adjuvant) only: The member exceeds two years of total Alecensa (alectinib) treatment and member has experienced disease progression while on Alecensa (alectinib).
Required Medical Information	Non-small Cell Lung Cancer: The member has recurrent or metastatic non-small cell lung cancer AND The member has documented anaplastic lymphoma kinase (ALK)-positive disease AND The member will be using Alecensa (alectinib) as monotherapy. Non-small Cell Lung Cancer (Adjuvant): The member has a diagnosis of non-small cell lung cancer (NSCLC) [i.e., tumors greater than or equal to 4 cm or node positive] AND The member will be using Alecensa (alectinib) for adjuvant treatment following complete tumor resection AND The member has documented anaplastic lymphoma kinase (ALK)-positive disease AND The member will be using Alecensa (alectinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ALIMTA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NSCLC (non-squamous): Squamous cell non-small cell lung cancer. Creatinine clearance (CrCl) less than 45 ml/minute. All other indications: Creatinine clearance (CrCl) less than 45 ml/minute.
Required Medical Information	Non-Small Cell Lung Cancer (Nonsquamous). The member has a diagnosis of non-squamous locally advanced or metastatic non-small cell lung cancer (NSCLC) AND One of the following applies: Pemetrexed will be used in combination with cisplatin or carboplatin therapy OR Pemetrexed will be used in a cisplatin or carboplatin-based regimen in combination with bevacizumab product OR Pemetrexed will be used as a single agent OR The member has no documented EGFR or ALK genomic tumor aberrations and pemetrexed will be given in combination with Keytruda (pembrolizumab) and carboplatin or cisplatin as first line therapy, followed by maintenance Keytruda (pembrolizumab) in combination with pemetrexed.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Malignant Pleural Mesothelioma. Diagnosis of malignant pleural mesothelioma.
Part B Prerequisite	0

ALIQOPA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib)
Required Medical Information	Follicular Lymphoma: The member has a diagnosis of follicular lymphoma AND The member has relapsed, refractory, or progressive disease AND The member has received at least two prior systemic therapies AND The member will be using Aliqopa as monotherapy
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	NA
Part B Prerequisite	0

ALKINDI SPRINKLE - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pediatric Adrenocortical Insufficiency: The member has a diagnosis of pediatric adrenocortical insufficiency AND The member has a documented contraindication to hydrocortisone tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

alosetron - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of severe diarrhea-predominant irritable bowel syndrome, AND The member has chronic IBS symptoms (lasting 6 months or longer), AND The member has had previous treatment with, contraindication, or intolerance to at least two of the following: loperamide, a tricyclic antidepressant (e.g. amitriptyline, nortriptyline, imipramine HCl, desipramine), or Xifaxan.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ALTACE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ALTRENO - LOTION (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ALUNBRIG - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-Small cell lung cancer: The member has a diagnosis of advanced or metastatic NSCLC with documented anaplastic lymphoma kinase (ALK) positivity AND Alunbrig will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ALVAIZ - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Refractory Severe Aplastic Anemia: A hematologic response has not occurred after 16 weeks of Alvaiz therapy.
Required Medical Information	Chronic Idiopathic Thrombocytopenic Purpura (ITP) (Initial): The member has a diagnosis of relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) AND The member has a platelet count of less than 50 x 10 ⁹ /L AND The member has had an insufficient response or is intolerant to corticosteroids OR The member has had a splenectomy with an inadequate response AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. (Continuation): For 54mg dosage requests: the member is not experiencing clinically significant bleeding AND The member has a platelet count of less than 400 x 10 ⁹ /L. Thrombocytopenia in Patients with Hepatitis C Infection (Initial): The member has a diagnosis of chronic hepatitis C AND The member has a platelet count of less than 75 x 10 ⁹ /L AND The degree of thrombocytopenia is preventing the initiation of interferon-based antiviral therapy OR limits the ability to maintain optimal interferon-based antiviral therapy. (Continuation): The member continues to receive interferon-based antiviral therapy AND The member has a platelet count of less than 400 x 10 ⁹ /L. Refractory Severe Aplastic Anemia (Initial): The member has a diagnosis of severe aplastic anemia AND The member has refractory disease, i.e., had an insufficient response to at least one immunosuppressive therapy (e.g. cyclosporine, h-ATG). (Continuation): The member has a platelet count of less than 400 x 10 ⁹ /L.
Age Restriction	Thrombocytopenia in Patients with Hepatitis C Infection and Refractory Severe Aplastic Anemia: The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial and continuation: 6 months durations.
Other Criteria	
Part B Prerequisite	0

ALYFTREK - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis: The member must meet ALL of the following criteria: Diagnosis of Cystic Fibrosis AND Prior lab testing with documentation of a mutation in the CFTR gene that is responsive to therapy based on clinical literature and/or in vitro assay data AND Previous treatment, contraindication, or intolerance to Trikafta.
Age Restriction	
Prescriber Restriction	The member is being treated by or in consultation with a specialist (e.g. pulmonologist).
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ALYGLO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ALYGLO - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

ALYMSYS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Malignant Pleural Mesothelioma, Soft Tissue Sarcoma, Recurrent Primary CNS Tumor (including Glioblastoma multiforme), Renal Cell Carcinoma, Non-small cell lung cancer (non-squamous cell histology): The member has experienced disease progression while on or following a bevacizumab product. Metastatic colorectal cancer: A bevacizumab product may not be used in conjunction with Vectibix (panitumumab) or Erbitux (cetuximab).
Required Medical Information	For Avastin (bevacizumab), Alymsys (bevacizumab-maly), Jobevne (bevacizumab-nwgd), and Vegzelma (bevacizumab-adcd) oncology requests: member must have an intolerance or contraindication with Mvasi or Zirabev. Metastatic colorectal cancer: metastatic colorectal cancer AND 1 of the following applies: using a bevacizumab product in combo with fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemo for 1st or 2nd-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemo for 2nd-line therapy in patients who have progressed on 1st-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). NSCLC with non-squamous cell histology AND the disease is unresectable, locally advanced, recurrent, or metastatic AND A bevacizumab product will be used as part of a supported combination chemotherapy. Hepatocellular carcinoma: unresectable or metastatic HCC AND a bevacizumab product will be used as 1st line therapy in combo with an atezolizumab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ALYMSYS - VIAL (ML)

Other Criteria	Renal cell carcinoma: Member has RCC and a bevacizumab product will be used in combo with interferon alpha. Recurrent Primary CNS Tumor (including Glioblastoma multiforme): Diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND a bevacizumab product is being used as a single agent or in combo with irinotecan, carmustine, lomustine or temozolomide AND the member does not have a CNS hemorrhage. Soft Tissue Sarcoma: One of the following applies: Diagnosis of angiosarcoma AND a bevacizumab product is being used as a single agent OR The member has a diagnosis of solitary fibrous tumor and a bevacizumab product is being used in combo with temozolomide. Macular Retinal Edema. Avastin is being used to treat central or branch retinal vein occlusion with macular retinal edema. Cervical Cancer: member has recurrent, or metastatic cervical cancer AND A bevacizumab product will be used as part of a supported combination therapy. Endometrial Cancer: The member has a diagnosis of endometrial cancer AND One of the following applies: The member has stage III-IV disease or recurrent disease AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, followed by maintenance with a bevacizumab product maintenance OR The member has recurrent disease AND a bevacizumab product monotherapy will be used as second-line or subsequent therapy if not previously used. Malignant Pleural Mesothelioma. Diagnosis of unresectable malignant pleural mesothelioma and a bevacizumab product will be used in combo with cisplatin and pemetrexed or carboplatin and pemetrexed followed by maintenance with a bevacizumab product (for responders). Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer AND One of the following applies: The disease is recurrent, platinum-resistant AND a bevacizumab product will be used in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan AND the member has not received more than 2 prior chemotherapy regimens OR The disease is recurrent, platinum-sensitive AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, or in combination with carboplatin and gemcitabine, followed by a bevacizumab product monotherapy AND The disease is stage III or IV AND initial surgical resection was completed AND a bevacizumab product will be used in combo with carboplatin and paclitaxel, followed by a bevacizumab product monotherapy OR . Age Related Macular Degeneration (Avastin requests only): Avastin (bevacizumab) is being used to treat age related macular degeneration. Diabetic Macular Edema (Avastin requests only): Avastin (bevacizumab) is being used to treat diabetic macular edema.
Part B Prerequisite	0

alyq - TABLET

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

AMBIEN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AMBIEN CR - TABLET, EXTENDED RELEASE MULTIPHASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ambrisentan - TABLET

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member has a diagnosis of idiopathic pulmonary fibrosis.
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

AMITIZA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	IBS-C: The member must have a diagnosis of irritable bowel syndrome with constipation AND The member has had previous treatment, intolerance, or contraindication to Linzess (linaclotide) and lubiprostone. CIC: The member must have a diagnosis of chronic idiopathic constipation AND The member has had previous treatment, intolerance, or contraindication to Linzess (linaclotide) and lubiprostone. OIC: Member has a diagnosis of opioid-induced constipation AND Member has taken an opioid agonist for at least 4 weeks for non-cancer pain, including pain related to prior cancer or its treatment that does not require frequent (e.g., weekly) opioid dose increases AND The member must have had previous treatment, intolerance, or contraindication to lubiprostone and Movantik (naloxegol).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AMJEVITA(CF) - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

AMJEVITA(CF) - SYRINGE (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

AMJEVITA(CF) AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

AMJEVITA(CF) AUTOINJECTOR - AUTO-INJECTOR (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

AMPYRA - TABLET, EXTENDED RELEASE 12 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	History of seizure disorder. Moderate to severe renal impairment (CrCl 50ml/min or less).
Required Medical Information	Multiple Sclerosis: Member has a diagnosis of multiple sclerosis AND Patient must be ambulatory AND The member has evidence of significant walking impairment related to multiple sclerosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AMVUTTRA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis: the member has documentation in the medical record of mutation in the TTR gene AND the member currently experiences polyneuropathy, and a comprehensive neurologic examination has ruled out other known causes of sensorimotor/autonomic neuropathy (e.g. chronic inflammatory demyelinating polyneuropathy) AND member has a polyneuropathy disability score of IIB or lower AND the member does not have a history of a previous liver transplant. Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): Member has a history of NYHA Class I through III Heart Failure AND Member has a diagnosis of ATTR-CM defined as: Significant cardiac involvement (e.g. substantial ventricular wall thickening or elevated intra-cardiac filling pressures) on echocardiography or cardiac MRI AND one of the following: Medical records indicate presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) OR Medical records indicate presence of amyloid deposits on analysis of biopsy specimens AND Member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, or Left Ventricular Assist Device (LVAD).
Age Restriction	
Prescriber Restriction	ATTR-CM: Member is being treated by a specialist (e.g. cardiologist). All other indications: Licensed Practitioner.
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AMZEEQ - FOAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acne Vulgaris: Member must be using to treat inflammatory lesions of non-nodular moderate to severe acne vulgaris AND Must have had previous treatment, intolerance, or contraindication with a topical retinoid (e.g. tretinoin (non-micro)*, adapalene 0.1% gel AND Must have had previous treatment, intolerance, or contraindication with one of the following oral products: non-delayed release minocycline or non-delayed release doxycycline (e.g. doxycycline monohydrate 50 mg capsule/tablet or 100mg capsule/tablet). * (Tretinoin non-micro has additional prior authorization requirements).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ANDEMBRY AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Prophylaxis. The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member must be using Andembry for prophylaxis to prevent attacks of HAE. The member has had previous treatment, contraindication or intolerance with appropriately dosed Haegarda (C1 esterase inhibitor) for HAE prophylaxis. Documentation details must be submitted for one of the following: trial of Haegarda and the member's response, member's specific contraindication to Haegarda, OR describing the side effects observed with Haegarda.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ANDROGEL - GEL IN METERED-DOSE PUMP

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ANKTIVA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on Anktiva (nogapendekin alfa inbakicept-pmln).
Required Medical Information	Non-muscle invasive bladder cancer (NMIBC): Member has a diagnosis of non-muscle invasive bladder cancer (NMIBC) with documented carcinoma in situ (CIS) AND The disease is documented as Bacillus Calmette-Guerin (BCG)-unresponsive, which is defined as persistent or recurrent disease following adequate BCG therapy (Adequate BCG is defined as the administration of at least five of six doses of an initial induction course plus either of: at least two of three doses of maintenance therapy or at least two of six doses of a second induction course) AND Member is ineligible for or has elected not to undergo cystectomy AND Anktiva (nogapendekin alfa inbakicept-pmln) will be used concurrently with Bacillus Calmette-Guerin (BCG).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	
Part B Prerequisite	0

ANORO ELLIPTA - BLISTER, WITH INHALATION DEVICE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema AND the member has had previous treatment, contraindication, or intolerance to Stiolto Respimat AND Spiriva Respimat OR Spiriva Handihaler.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ANZUPGO - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Hand Eczema: Anzupgo will be used for treatment of moderate to severe chronic hand eczema (CHE) AND Has had previous treatment, intolerance, or contraindication to at least TWO topical corticosteroids of moderate or higher potency (e.g., triamcinolone, mometasone, betamethasone, or clobetasol cream/ointment) AND Topical application of Anzupgo will be limited to hands and wrists affected by CHE.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

APOKYN - CARTRIDGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease off episodes: The member has a diagnosis of Parkinson's disease AND is currently taking carbidopa/levodopa and will continue taking carbidopa/levodopa with Apokyn (apomorphine) AND is experiencing breakthrough off periods related to their Parkinson's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

apomorphine - CARTRIDGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease off episodes: The member has a diagnosis of Parkinson's disease AND is currently taking carbidopa/levodopa and will continue taking carbidopa/levodopa with Apokyn (apomorphine) AND is experiencing breakthrough off periods related to their Parkinson's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

APTOM - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND Member will not use Aptiom (eslicarbazepine) in combination with oxcarbazepine AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AQNEURSA - GRANULES IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of Niemann Pick disease type C (NPC) AND Provider attests that the diagnosis has been confirmed by one of the following: Genetically confirmed by mutations in both alleles of NPC1 or NPC2 OR Mutation in one allele of NPC1 or NPC2 AND either positive filipin staining OR elevated cholestane triol/oxysterols (greater than 2 times the upper limit of normal) AND Member weighs greater than or equal to 15kg AND Member has at least one neurological symptom of the disease (e.g., hearing loss, difficulty swallowing, fine motor skill loss, difficulty walking).
Age Restriction	
Prescriber Restriction	Aqneursa is prescribed by or in consultation with a provider with expertise in the treatment of Niemann-Pick disease type C.
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AQVESME - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Has a diagnosis of cirrhosis of the liver (Child Pugh Class A, B, or C).
Required Medical Information	Alpha- or Beta-Thalassemia: Is an adult with a diagnosis of alpha- or beta-thalassemia AND Is using Aqvesme for the treatment of anemia related to alpha- or beta-thalassemia AND One of the following is true (Applies to new starts only): Has a baseline hemoglobin level less than or equal to 10 g/dL before any treatment (including transfusions) OR Has required 6 to 20 red blood cell (RBC) units transfused in the prior 24 weeks.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial and Renewal: Plan year duration
Other Criteria	
Part B Prerequisite	0

ARALAST NP - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	IgA deficient members or presence of antibodies against IgA.
Required Medical Information	The member must meet ALL of the following criteria: Diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed AND Has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or PI (null, null) or phenotypes associated with reduced serum alpha-1 antitrypsin concentrations, AND an initial serum alpha 1-antitrypsin concentration of less than 57mg/dL when measured by nephelometry OR less than 80 mg/dL when measured by radial immunodiffusion. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema.) For requests for Prolastin-C, Glassia and Aralast-NP: The member must have prior therapy with, intolerance to, or contraindication to Zemaira.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARANESP (IN POLYSORBATE) - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Anemia in Chemotherapy Treated Cancer Members. Initiation Phase (first four-to-six weeks). Diagnosis with a non-myeloid, non-erythroid malignancy. Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than 10.0 g/dL or HCT less than 30 (within the last 4 weeks). Must have had an inadequate response to Retacrit therapy for at least 2 consecutive months with appropriate dose adjustment for pharmacy claims. Maintenance Phase (after first four-to-six weeks). Member has responded to therapy, defined as one or more of the following: increase in hemoglobin of at least 1 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements OR member has experienced symptom improvement and prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level sufficient to avoid RBC transfusion.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration for all indications. Reauth: plan year duration.

ARANESP (IN POLYSORBATE) - VIAL (ML)

Other Criteria	Anemia of Chronic Kidney Disease. Initial Therapy. Diagnosis of anemia associated with CKD (i.e., chronic renal failure or equivalent). Must have a Hgb level less than 10 g/dL or HCT less than 30 (within the last four weeks). Must have had an inadequate response to Retacrit therapy for at least two consecutive months with appropriate dose adjustment (for pharmacy claims only). Continuing Therapy: Current (within the last four weeks) Hgb level less than 11 g/dL OR documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Anemia in Myelodysplastic Syndromes: Initial Therapy: Diagnosis of symptomatic anemia associated with myelodysplastic syndrome. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL (MDS members with an erythropoietin level greater than 500 mUnits/mL are very unlikely to respond to ESA therapy). Must have Hgb level less than 12 g/dL or HCT less than 30 (within the last four weeks). Must have had an inadequate response to Retacrit therapy for at least 2 consecutive months with appropriate dose adjustment for pharmacy claims. Continuing Therapy. Must meet ALL of the following criteria: Member has attained a response defined as a 1.5 g/dL rise in Hgb (not to exceed 12 g/dL) or a decrease in RBC transfusion requirement. For listed indications: Prior to initiation of therapy, other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Prior to initiation of therapy, the member's iron scores should be evaluated. Transferrin saturation should be at least 20% or ferritin at least 100 ng/mL within the last 4 months (applies to most recent result). Continuation of therapy requires documented Transferrin saturation of at least 20% or ferritin of at least 100 ng/ mL within the last 4 months for all indications (applies to most recent result).
Part B Prerequisite	0

ARAVA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARAZLO - LOTION (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Cosmetic indications including solar lentigines, wrinkles, or roughness of the skin in the absence of an approvable indication described in the coverage determination section.
Required Medical Information	Acne Vulgaris. The member must have a diagnosis of acne vulgaris AND The member must have had previous treatment with, intolerance or contraindication to tretinoin (non-micro) or adapalene 0.1% gel.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARCALYST - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Familial Cold Autoinflammatory Syndrome or Muckle-Wells Syndrome: The member has a diagnosis of Cryopyrin-Associated Periodic Syndrome (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS). Recurrent Pericarditis: Member has a diagnosis of recurrent pericarditis defined by: presentation of symptoms of acute pericarditis after a symptom-free interval of at least 4 weeks. Deficiency of Interleukin-1 Receptor Antagonist (DIRA) The member has a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA).
Age Restriction	Member must be 12 years of age or older for Familial Cold Autoinflammatory Syndrome, Muckle-Wells Syndrome, and Recurrent Pericarditis indications. Age restriction does not apply to DIRA.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARICEPT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARIKAYCE - VIAL, NEBULIZER (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use of Arikayce as monotherapy. Use of Arikayce for non-MAC infections or for non-refractory or disseminated MAC. Continued use of Arikayce in members that failed to achieve negative sputum cultures after 6 months of therapy with Arikayce.
Required Medical Information	Mycobacterium avium Complex (MAC) Lung Disease. Member must have a diagnosis of Mycobacterium avium complex (MAC) lung disease. Member must have failed to achieve negative sputum cultures after a minimum of 6 consecutive months of a multi-drug regimen. Member must have limited or no alternative treatment options. Arikayce will be used as part of a multi-drug regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARIMIDEX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARIXTRA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

armodafinil - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must utilize Nuvigil (armodafinil) for the treatment of excessive daytime sleepiness or hypersomnolence associated with narcolepsy, obstructive sleep apnea or due to sleep problems resulting from circadian rhythm disruption (i.e., shift-work sleep disorder). For Brand Nuvigil Requests only: The member must have had previous treatment, intolerance, or contraindication to armodafinil or modafinil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AROMASIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

arsenic trioxide - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Promyelocytic Leukemia (APL). The member has a diagnosis of acute promyelocytic leukemia AND the member will be using Trisenox (arsenic trioxide) for induction therapy, consolidation therapy, or relapsed disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ARTHROTEC 50 - TABLET,IMMEDIATE,DELAY RELEASE,BIPHASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARTHROTEC 75 - TABLET,IMMEDIATE,DELAY RELEASE,BIPHASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ARYNTA - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

ASCENIV - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ASCENIV - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

asenapine maleate - TABLET, SUBLINGUAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia/Bipolar I Disorder, manic or mixed episodes. The member must be utilizing asenapine for treatment of schizophrenia or bipolar I disorder. The member must have prior therapy or intolerance or contraindication to at least two of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ASPARLAS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members that have experienced disease progression while on or following Asparlas (calaspargase pegol-mknl). Members with a history of serious thrombosis with prior asparaginase therapy. Members with a history of pancreatitis with prior asparaginase therapy. Members with a history of serious hemorrhagic events with prior asparaginase therapy. Members with total bilirubin more than 10 times the upper limit of normal.
Required Medical Information	Acute Lymphoblastic Leukemia (ALL): The member has a diagnosis of acute lymphoblastic leukemia (ALL) AND The member will be using Asparlas (calaspargase pegol-mknl) as a component of a multi-agent chemotherapy regimen.
Age Restriction	The age of the member is less than or equal to 21 years.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA
Part B Prerequisite	0

ATACAND - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ATACAND HCT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ATELVIA - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ATGAM - AMPUL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Aplastic Anemia: Members with aplastic anemia secondary to neoplastic disease, storage disease, myelofibrosis, or Fanconi's syndrome. Members known to have been exposed to myelotoxic agents or radiation.
Required Medical Information	Aplastic Anemia: The member must have a diagnosis of moderate or severe aplastic anemia. The member is not a suitable candidate for bone marrow transplantation. Renal transplant rejection: The member must have received a renal transplant. The member must utilize Atgam (antithymocyte immune globulin, equine) for the management of allograft rejection. The member must receive conventional therapy for transplant rejection concurrently. Renal transplant rejection, prophylaxis: The member must have received a renal transplant. The member must utilize Atgam (antithymocyte immune globulin, equine) for the prevention of allograft rejection. The member must receive conventional therapy for transplant rejection concurrently. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	28 day duration.
Other Criteria	
Part B Prerequisite	0

ATIVAN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ATMEKSI - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Musculoskeletal Pain: member is using this product as adjunct to rest, physical therapy, and other measures for relief of musculoskeletal pain associated with acute, painful musculoskeletal conditions AND has had a trial with, intolerance, or contraindication to methocarbamol 500 mg tablets AND 750 mg tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ATRALIN - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ATROVENT HFA - HFA AEROSOL WITH ADAPTER (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema. The member has had previous treatment, contraindication, or intolerance to Spiriva (i.e. Spiriva Handihaler, Spiriva Respimat). For Yupelri requests: BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ATTRUBY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): Member has a history of NYHA Class I through III Heart Failure AND Member has a diagnosis of ATTR-CM defined as: Significant cardiac involvement (e.g. substantial ventricular wall thickening or elevated intra-cardiac filling pressures) on echocardiography or cardiac MRI AND one of the following: Medical records indicate presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) OR Medical records indicate presence of amyloid deposits on analysis of biopsy specimens AND Member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, or Left Ventricular Assist Device (LVAD).
Age Restriction	
Prescriber Restriction	Member is being treated by a specialist (e.g. cardiologist).
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AUBAGIO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AUGMENTIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AUGTYRO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	ROS1 Positive NSCLC: Member has diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND Member has disease which is ROS-1 rearrangement(s) positive AND Member will be using Augtyro (repotrectinib) as monotherapy. NTRK Gene Fusion-Positive Solid Tumors: The member has a diagnosis of solid tumors which are metastatic OR the member is not a candidate for surgical resection AND The member has a documented neurotrophic tyrosine receptor kinase (NTRK) gene fusion AND The members disease has progressed following treatment or does not have satisfactory alternative therapy options AND Member will be using Augtyro (repotrectinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

auranofin - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must have a diagnosis of active rheumatoid arthritis AND must have had prior therapy, contraindication or intolerance with a nonsteroidal anti-inflammatory drug (e.g. meloxicam, celecoxib) AND a conventional disease-modifying antirheumatic drug (e.g. methotrexate, leflunomide, sulfasalazine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AUSTEDO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	TD: The member is utilizing Austedo (deutetrabenazine) or Austedo XR for the treatment of tardive dyskinesia that is associated with the use of dopamine receptor blocking agents AND Symptoms persist despite one of the following: Discontinuation or reduction in dose of dopamine blocking agent(s) OR Discontinuation or reduction in dose of dopamine blocking agent(s) is not possible. OR the member is utilizing Austedo (deutetrabenazine) or Austedo XR for the treatment of TD that is not associated with other medication therapies (e.g. dopamine receptor-blocking agents). Chorea with HD: Diagnosis of chorea associated with Huntington's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AUSTEDO XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	TD: The member is utilizing Austedo (deutetrabenazine) or Austedo XR for the treatment of tardive dyskinesia that is associated with the use of dopamine receptor blocking agents AND Symptoms persist despite one of the following: Discontinuation or reduction in dose of dopamine blocking agent(s) OR Discontinuation or reduction in dose of dopamine blocking agent(s) is not possible. OR the member is utilizing Austedo (deutetrabenazine) or Austedo XR for the treatment of TD that is not associated with other medication therapies (e.g. dopamine receptor-blocking agents). Chorea with HD: Diagnosis of chorea associated with Huntington's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AUSTEDO XR TITRATION KT(WK1-4) - TABLET, EXTENDED RELEASE 24 HR DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	TD: The member is utilizing Austedo (deutetrabenazine) or Austedo XR for the treatment of tardive dyskinesia that is associated with the use of dopamine receptor blocking agents AND Symptoms persist despite one of the following: Discontinuation or reduction in dose of dopamine blocking agent(s) OR Discontinuation or reduction in dose of dopamine blocking agent(s) is not possible. OR the member is utilizing Austedo (deutetrabenazine) or Austedo XR for the treatment of TD that is not associated with other medication therapies (e.g. dopamine receptor-blocking agents). Chorea with HD: Diagnosis of chorea associated with Huntington's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AVALIDE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AVAPRO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AVASTIN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Malignant Pleural Mesothelioma, Soft Tissue Sarcoma, Recurrent Primary CNS Tumor (including Glioblastoma multiforme), Renal Cell Carcinoma, Non-small cell lung cancer (non-squamous cell histology): The member has experienced disease progression while on or following a bevacizumab product. Metastatic colorectal cancer: A bevacizumab product may not be used in conjunction with Vectibix (panitumumab) or Erbitux (cetuximab).
Required Medical Information	For Avastin (bevacizumab), Alymsys (bevacizumab-maly), Jobevne (bevacizumab-nwgd), and Vegzelma (bevacizumab-adcd) oncology requests: member must have an intolerance or contraindication with Mvasi or Zirabev. Metastatic colorectal cancer: metastatic colorectal cancer AND 1 of the following applies: using a bevacizumab product in combo with fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemo for 1st or 2nd-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemo for 2nd-line therapy in patients who have progressed on 1st-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). NSCLC with non-squamous cell histology AND the disease is unresectable, locally advanced, recurrent, or metastatic AND A bevacizumab product will be used as part of a supported combination chemotherapy. Hepatocellular carcinoma: unresectable or metastatic HCC AND a bevacizumab product will be used as 1st line therapy in combo with an atezolizumab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

AVASTIN - VIAL (ML)

Other Criteria	Renal cell carcinoma: Member has RCC and a bevacizumab product will be used in combo with interferon alpha. Recurrent Primary CNS Tumor (including Glioblastoma multiforme): Diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND a bevacizumab product is being used as a single agent or in combo with irinotecan, carmustine, lomustine or temozolomide AND the member does not have a CNS hemorrhage. Soft Tissue Sarcoma: One of the following applies: Diagnosis of angiosarcoma AND a bevacizumab product is being used as a single agent OR The member has a diagnosis of solitary fibrous tumor and a bevacizumab product is being used in combo with temozolomide. Macular Retinal Edema. Avastin is being used to treat central or branch retinal vein occlusion with macular retinal edema. Cervical Cancer: member has recurrent, or metastatic cervical cancer AND A bevacizumab product will be used as part of a supported combination therapy. Endometrial Cancer: The member has a diagnosis of endometrial cancer AND One of the following applies: The member has stage III-IV disease or recurrent disease AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, followed by maintenance with a bevacizumab product maintenance OR The member has recurrent disease AND a bevacizumab product monotherapy will be used as second-line or subsequent therapy if not previously used. Malignant Pleural Mesothelioma. Diagnosis of unresectable malignant pleural mesothelioma and a bevacizumab product will be used in combo with cisplatin and pemetrexed or carboplatin and pemetrexed followed by maintenance with a bevacizumab product (for responders). Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer AND One of the following applies: The disease is recurrent, platinum-resistant AND a bevacizumab product will be used in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan AND the member has not received more than 2 prior chemotherapy regimens OR The disease is recurrent, platinum-sensitive AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, or in combination with carboplatin and gemcitabine, followed by a bevacizumab product monotherapy AND The disease is stage III or IV AND initial surgical resection was completed AND a bevacizumab product will be used in combo with carboplatin and paclitaxel, followed by a bevacizumab product monotherapy OR . Age Related Macular Degeneration (Avastin requests only): Avastin (bevacizumab) is being used to treat age related macular degeneration. Diabetic Macular Edema (Avastin requests only): Avastin (bevacizumab) is being used to treat diabetic macular edema.
Part B Prerequisite	0

AVEED - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AVELOX IN NACL (ISO-OSMOTIC) - INTRAVENOUS SOLUTION, PIGGYBACK (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AVITA - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AVLAYAH - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

AVMAPKI-FAKZYNJA - COMBINATION PACKAGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Avmapki (avutometinib)-Fakzynja (defactinib).
Required Medical Information	Ovarian Cancer: The member has a diagnosis of recurrent low-grade serous ovarian cancer (LGSOC) AND The disease is documented as KRAS mutation-positive AND The member has received previous systemic therapy AND Avmapki (avutometinib) will be used in combination with Fakzynja (defactinib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AVODART - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AVONEX - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AVSOLA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Combination therapy with other biologics (e.g. Cosentyx, Enbrel, adalimumab product, Kevzara, Remicade).
Required Medical Information	Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis AND the member must be on concomitant treatment with methotrexate during therapy, unless contraindicated or intolerant to methotrexate AND the member has failed to achieve symptom control (e.g. reduced joint pain, reduced joint swelling) or has intolerance with one of the following: Remicade, Inflectra, unbranded infliximab, or Simponi Aria. Fistulizing Crohn's Disease: Diagnosis of Crohn's disease with one or more draining fistulas. The member has had prior therapy, contraindication, or intolerance with one or more immunosuppressive agents (e.g. azathioprine, 6-mercaptopurine). The member has failed to achieve symptom control (e.g. improved liquid or soft stool, reduced abdominal pain, stable weight) or has intolerance with Remicade OR Inflectra OR unbranded infliximab. Crohns Disease (non-fistulizing) and Ulcerative Colitis - Adult: Diagnosis of moderate to severely active Crohns disease or moderate to severely active ulcerative colitis. The member has failed to achieve symptom control (e.g. improved liquid or soft stool, reduced abdominal pain, stable weight) or has intolerance with: Remicade OR Inflectra OR unbranded infliximab, AND the member has had prior therapy, contraindication, or intolerance with a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Ankylosing Spondylitis: Diagnosis of highly persistent, active ankylosing spondylitis. Member has failed to achieve symptoms control (e.g. reduced spinal pain, reduced inflammation) or has intolerance with one of the following: Remicade, Inflectra, unbranded infliximab or Simponi Aria.
Age Restriction	Must be 18 years of age for Plaque Psoriasis, Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Fistulizing Crohn's Disease. Must be 6 years of age for Crohn's Disease (Non-Fistulizing) and Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

AVSOLA - VIAL (EA)

Other Criteria	Psoriatic arthritis: Diagnosis of active psoriatic arthritis AND one of the following criteria are met: the member has failed to achieve symptom control (e.g. reduced joint pain or swelling, reduced erythema) or has intolerance with Remicade, Inflectra, unbranded infliximab OR Simponi Aria, AND The member has had prior therapy, contraindication or intolerance with a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek). Plaque Psoriasis: Diagnosis of moderate to severe, extensive chronic plaque psoriasis. The member has failed to achieve symptom control (e.g. reduction in erythema, reduction of area of skin involved) or has intolerance with Remicade, Inflectra, OR unbranded infliximab. The member has had prior therapy, contraindication or intolerance with a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek). Crohns disease and Ulcerative Colitis - pediatrics: Diagnosis of moderately to severely active Crohns disease or moderately to severely active ulcerative colitis. The member has failed to achieve symptom control (e.g. reduced stool frequency, reduced rectal bleeding) or has intolerance with Remicade or Inflectra or unbranded infliximab.
Part B Prerequisite	0

AVTOZMA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderately to Severely Active Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Systemic Juvenile Idiopathic Arthritis: The member must have a diagnosis of active systemic juvenile idiopathic arthritis (SJIA) or as formerly known, systemic juvenile rheumatoid arthritis. Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): The member has a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) confirmed by the following criteria: High Resolution Computer Tomography (HRCT) OR Lung Biopsy. Tocilizumab is prescribed by, or in consultation with, a specialist (e.g. a rheumatologist) with experience in the treatment of SSc-ILD. The member has had prior therapy, contraindication, or intolerance with mycophenolate mofetil. Giant Cell Arteritis: The member must have a diagnosis of giant cell arteritis AND the member must have tried or cannot use Tyenne AND Rinvoq.
Age Restriction	Member must be 18 years and older. For the treatment of PJIA and SJIA the member must be at least 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AVTOZMA AUTOINJECTOR - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderately to Severely Active Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Systemic Juvenile Idiopathic Arthritis: The member must have a diagnosis of active systemic juvenile idiopathic arthritis (SJIA) or as formerly known, systemic juvenile rheumatoid arthritis. Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): The member has a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) confirmed by the following criteria: High Resolution Computer Tomography (HRCT) OR Lung Biopsy. Tocilizumab is prescribed by, or in consultation with, a specialist (e.g. a rheumatologist) with experience in the treatment of SSc-ILD. The member has had prior therapy, contraindication, or intolerance with mycophenolate mofetil. Giant Cell Arteritis: The member must have a diagnosis of giant cell arteritis AND the member must have tried or cannot use Tyenne AND Rinvoq.
Age Restriction	Member must be 18 years and older. For the treatment of PJIA and SJIA the member must be at least 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AXTLE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-Small Cell Lung Cancer (Nonsquamous). The member has a diagnosis of non-squamous locally advanced or metastatic non-small cell lung cancer (NSCLC) AND One of the following applies: Pemetrexed will be used in combination with cisplatin or carboplatin therapy OR Pemetrexed will be used in a cisplatin or carboplatin-based regimen in combination with bevacizumab product OR Pemetrexed will be used as a single agent OR The member has no documented EGFR or ALK genomic tumor aberrations and pemetrexed will be given in combination with Keytruda (pembrolizumab) and carboplatin or cisplatin as first line therapy, followed by maintenance Keytruda (pembrolizumab) in combination with pemetrexed.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Malignant Pleural Mesothelioma. Diagnosis of malignant pleural mesothelioma.
Part B Prerequisite	0

AYVAKIT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Ayvakit (avapritinib). [Applicable to all indications except Gastrointestinal stromal tumor (GIST)]
Required Medical Information	Gastrointestinal Stromal tumor. The member has documented PDGFRA exon 18 mutation-positive unresectable or metastatic gastrointestinal stromal tumor (including PDGFRA D842V) AND Ayvakit (avapritinib) will be given as monotherapy. Advanced systemic mastocytosis: The member has a diagnosis of advanced systemic mastocytosis (AdvSM), including systemic mastocytosis with an associated hematological neoplasm and mast cell leukemia AND Ayvakit is not recommended for the treatment of members with AdvSM with platelet counts of less than $50 \times 10^9 /L$ AND Ayvakit (avapritinib) is administered as monotherapy. Indolent Systemic Mastocytosis (ISM). The member has a diagnosis of Indolent Systemic Mastocytosis (ISM) AND is not recommended for treatment of members with documented platelet counts of less than $50 \times 10^9 /L$ AND Ayvakit (avapritinib) is administered as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

azacitidine - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Myelodysplastic Syndromes. The member has a diagnosis of myelodysplastic syndrome AND one of the following scenarios apply: The member has a Revised International Prognostic Scoring System (IPSS-R) of higher risk disease (i.e. intermediate, high, very high) OR The member has a Revised International Prognostic Scoring System (IPSS-R) of lower risk disease (i.e. very low, low, or intermediate) AND one of the following sets of criteria applies: Clinically relevant thrombocytopenia, neutropenia, or increased marrow blasts OR Member has symptomatic anemia AND No 5q deletion AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND Serum erythropoietin levels less than or equal to 500 mU/mL AND An inadequate response to erythropoietins alone or in combination with Revlimid (lenalidomide) AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND 5q deletion AND An inadequate response or intolerance to Revlimid (lenalidomide) AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy. Myeloproliferative Neoplasms: The member has a diagnosis of myelofibrosis (MF)-accelerated phase or MF-blast phase/acute myeloid leukemia. Acute Myelogenous Leukemia (AML). The member has a diagnosis of AML.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

AZACTAM - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AZILECT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

AZMIRO - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

AZOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BAFIERTAM - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BALVERSA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Urothelial Cancer: The member has a diagnosis of locally advanced or metastatic urothelial carcinoma AND the member has identification of a susceptible FGFR3 genetic alteration documented in the medical record [e.g., FGFR3 gene mutations (R248C, S249C, G370C, Y373C), FGFR3 gene fusions (FGFR3-TACC3v1, FGFR3-TACCv3, FGFR3-TACC3, FGFR3-BAIAP2L1)] AND the member will be using Balversa (erdafitinib) as a single agent for subsequent therapy after disease progression during or following at least one prior line of systemic therapy, including a PD-1 (Programmed cell death protein 1) or PD-L1 (Programmed death-ligand 1) inhibitor [e.g., avelumab, pembrolizumab] (if eligible).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

BANZEL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients with familial short QT syndrome.
Required Medical Information	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND Banzel (rufinamide) will be used in combination with at least one other drug for controlling seizures AND The member has been unable to achieve seizure control with at least one other drug used for the adjunctive treatment of Lennox-Gastaut syndrome (e.g., lamotrigine, topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BARACLUDE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BASAGLAR KWIKPEN U-100 INSULIN - INSULIN PEN (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of type 1 or type 2 diabetes mellitus AND The member has had previous treatment or intolerance with at least one preferred insulin glargine product: Lantus, Lantus Solostar OR Toujeo AND insulin degludec (i.e. Tresiba).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BASAGLAR TEMPO PEN(U-100)INSLN - INSULIN PEN, SENSOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of type 1 or type 2 diabetes mellitus AND The member has had previous treatment or intolerance with at least one preferred insulin glargine product: Lantus, Lantus Solostar OR Toujeo AND insulin degludec (i.e. Tresiba).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BAVENCIO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following PD-1/PD-L1 therapy (e.g Keytruda, Opdivo, Tecentriq, Imfinzi).
Required Medical Information	Merkel Cell Carcinoma (Adults). The member has a diagnosis of metastatic Merkel cell carcinoma AND Member will be using Bavencio as monotherapy. Merkel Cell Carcinoma (Pediatrics). The member has a diagnosis of metastatic Merkel cell carcinoma AND Member will be using Bavencio as monotherapy. Urothelial Cancer. The member has a diagnosis of locally advanced or metastatic urothelial cancer AND the member will be using Bavencio (avelumab) as monotherapy AND One of the following apply: The member will be using Bavencio (avelumab) as second or subsequent line systemic therapy OR the member has had disease progression within 12 months of neoadjuvant or adjuvant chemotherapy OR The member will be using Bavencio (avelumab) as maintenance treatment if there is no disease progression with first-line platinum-containing chemotherapy. Renal Cell Carcinoma. The member has a diagnosis of advanced or metastatic renal cell carcinoma AND Bavencio (avelumab) will be given in combination with Inlyta (axitinib) as first-line therapy.
Age Restriction	Pediatric Merkel Cell Carcinoma - member must be 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

BELEODAQ - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Beleodaq (belinostat). Members on concomitant Istodax (romidepsin), Zolinza (vorinostat), or Folutyn (pralatrexate) therapy.
Required Medical Information	Peripheral T-Cell Lymphoma (PTCL). The member must have a diagnosis of relapsed OR refractory peripheral T-cell lymphoma (PTCL).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	six month duration
Other Criteria	NA
Part B Prerequisite	0

bendamustine - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members who experience disease progression on bendamustine containing regimens.
Required Medical Information	Chronic Lymphocytic Leukemia (CLL). The member has a diagnosis of CLL AND bendamustine is being used for relapsed or refractory disease or as first line therapy. Multiple Myeloma (MM). The member has a diagnosis of MM AND bendamustine is being used for disease relapse or for progressive or refractory disease. Non-Hodgkin's Lymphoma: The member has a diagnosis of follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma or mantle cell lymphoma. The member has a diagnosis of primary cutaneous B-cell lymphoma (primary cutaneous marginal zone or follicle center B-cell lymphoma) and bendamustine is being used as a single agent or in combination with a rituximab product in one of the following: Refractory generalized cutaneous disease OR generalized extracutaneous disease as initial therapy or for relapse. The member has a diagnosis of splenic marginal zone lymphoma and bendamustine is being used as one of the following: First-line therapy for disease progression following initial treatment for splenomegaly OR Second-line or subsequent therapy for progressive disease. The member has a diagnosis of diffuse large B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy. The member has a diagnosis of AIDS-related B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Waldenstroms Macroglobulinemia: The member has Waldenstroms macroglobulinemia or lymphoplasmacytic lymphoma and bendamustine is being used as one of the following: Primary therapy OR Progressive or relapsed disease. Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND bendamustine will be used as subsequent therapy for relapsed or refractory disease.
Part B Prerequisite	0

BENDEKA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members who experience disease progression on bendamustine containing regimens.
Required Medical Information	Chronic Lymphocytic Leukemia (CLL). The member has a diagnosis of CLL AND bendamustine is being used for relapsed or refractory disease or as first line therapy. Multiple Myeloma (MM). The member has a diagnosis of MM AND bendamustine is being used for disease relapse or for progressive or refractory disease. Non-Hodgkin's Lymphoma: The member has a diagnosis of follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma or mantle cell lymphoma. The member has a diagnosis of primary cutaneous B-cell lymphoma (primary cutaneous marginal zone or follicle center B-cell lymphoma) and bendamustine is being used as a single agent or in combination with a rituximab product in one of the following: Refractory generalized cutaneous disease OR generalized extracutaneous disease as initial therapy or for relapse. The member has a diagnosis of splenic marginal zone lymphoma and bendamustine is being used as one of the following: First-line therapy for disease progression following initial treatment for splenomegaly OR Second-line or subsequent therapy for progressive disease. The member has a diagnosis of diffuse large B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy. The member has a diagnosis of AIDS-related B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Waldenstroms Macroglobulinemia: The member has Waldenstroms macroglobulinemia or lymphoplasmacytic lymphoma and bendamustine is being used as one of the following: Primary therapy OR Progressive or relapsed disease. Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND bendamustine will be used as subsequent therapy for relapsed or refractory disease.
Part B Prerequisite	0

BENICAR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BENICAR HCT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BENLYSTA - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Severe active central nervous system lupus.
Required Medical Information	Systemic Lupus Erythematosus (SLE): The member must have a diagnosis of active systemic lupus erythematosus (SLE). The member must be auto-antibody positive in the absence of any drugs for SLE defined as: ANA titer greater than or equal 1:80 or anti-dsDNA level greater than or equal 30 IU/mL. The member must be utilizing Benlysta (belimumab) in combination with standard treatment regimens for SLE which may include: corticosteroids (e.g. prednisone), hydroxychloroquine, azathioprine. Lupus Nephritis: The member must have a diagnosis of active lupus nephritis AND the member must be utilizing Benlysta in combination with standard therapy (e.g. corticosteroids with mycophenolate or cyclophosphamide).
Age Restriction	The member must be 5 years of age or older for Lupus Nephritis and Systemic Lupus Erythematosus (SLE).
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BERINERT - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE): The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member is using Berinert for the treatment of acute abdominal, facial, or laryngeal attacks of HAE. The member has had previous treatment, contraindication, or intolerance to generic icatibant. Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response, member's contraindication to generic icatibant, OR describing the side effects observed with generic icatibant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BESPONSA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on or following Besponsa (inotuzumab ozogamicin)
Required Medical Information	Acute Lymphoblastic Leukemia: The member has a diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL)AND The member has relapsed or refractory disease AND The member has documented CD22 blasts found in bone marrow or peripheral blood AND The member will be using Besponsa (inotuzumab ozogamicin) as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Six month durations (up to a maximum of 6 cycles)
Other Criteria	NA
Part B Prerequisite	0

BESREMI - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with hepatic decompensation (Child-Pugh score greater than 6 [class B and C]). Members that have experienced disease progression while on Besremi (ropeginterferon alfa-2b-njft). Members with existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation or suicide attempt. Members that are immunosuppressed transplant recipients. Members with Hypersensitivity to interferon or to any component of Besremi (ropeginterferon alfa-2b-njft). Members with history or presence of active serious or untreated autoimmune disease.
Required Medical Information	Polycythemia Vera: The member has a diagnosis of Polycythemia Vera.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BETAPACE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BETAPACE AF - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BETASERON - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BETHKIS - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with Pseudomonas aeruginosa. For Brand Requests: Prior therapy, intolerance to, or contraindication to generic tobramycin for inhalation. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

BEVESPI AEROSPHERE - HFA AEROSOL WITH ADAPTER (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema AND the member has had previous treatment, contraindication, or intolerance to Stiolto Respimat AND Spiriva Respimat OR Spiriva Handihaler.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

bexarotene - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that are pregnant.
Required Medical Information	Cutaneous T-cell Lymphoma (CTCL). (bexarotene capsules). The member will be using bexarotene as primary treatment OR Member has experienced disease progression, contraindication, or intolerance to at least one prior systemic therapy for cutaneous manifestations of cutaneous T-cell lymphoma. Cutaneous T-cell Lymphoma. (bexarotene 1% topical gel/jelly). The member will be using bexarotene as primary treatment OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BIDIL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Heart Failure: The member must meet ALL of the following criteria: Diagnosis of NYHA Class II-IV Heart Failure AND prior therapy of generic Bidil (isosorbide-hydralazine tablets).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BILTRICIDE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BIMZELX - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Non-Radiographic Axial Spondyloarthritis: The member has a diagnosis of active non-radiographic axial spondyloarthritis with objective signs of inflammation AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, or Rinvoq. Ankylosing Spondylitis: The member has a diagnosis of active ankylosing spondylitis AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa AND The member must have failed to achieve symptom control after previous treatment with a preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

BIMZELX AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Non-Radiographic Axial Spondyloarthritis: The member has a diagnosis of active non-radiographic axial spondyloarthritis with objective signs of inflammation AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, or Rinvoq. Ankylosing Spondylitis: The member has a diagnosis of active ankylosing spondylitis AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa AND The member must have failed to achieve symptom control after previous treatment with a preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

BIVIGAM - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

BIVIGAM - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

BIZENGRI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on Bizengri (zenocutuzumab-zbco).
Required Medical Information	Non-Small Cell Lung Cancer [NSCLC]: NRG1 Gene Fusion Positive (NRG1 +): The member has a diagnosis of advanced, unresectable or metastatic non-small cell lung cancer [NSCLC] AND The disease is documented as neuregulin 1 (NRG1) gene fusion positive AND The member has previously been treated with at least one prior line of systemic therapy AND Bizengri (zenocutuzumab-zbco) will be given as monotherapy. Pancreatic Adenocarcinoma: NRG1 Gene Fusion Positive (NRG1 +) AND The member has a diagnosis of advanced, unresectable or metastatic pancreatic adenocarcinoma AND The disease is documented as neuregulin 1 (NRG1) gene fusion positive AND The member has previously been treated with at least one prior line of systemic therapy AND Bizengri (zenocutuzumab-zbco) will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

BKEMV - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH): Documentation in the medical record supporting the diagnosis of PNH defined as granulocyte or monocyte clone size of greater than 5% AND Documentation in the medical record of an LDH level of 1.5 times the upper limit of the normal range AND One of the following: Member is transfusion dependent as defined as one of the following: Hemoglobin less than or equal to 7 g/dL OR Both of the following: Hemoglobin less than or equal to 9 g/dL AND Member is experiencing symptoms of anemia OR Member has a documented history of major adverse vascular events from thromboembolism (e.g., abdominal pain, shortness of breath, chest pain, end organ damage). Atypical Hemolytic Uremic Syndrome (aHUS): Documentation supporting the diagnosis of aHUS by ruling out both of the following: Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS) AND Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Generalized Myasthenia Gravis (gMG): the member has a diagnosis of generalized myasthenia gravis AND the presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND the member is being treated by, or under the supervision of, a specialty (e.g. neurologist) experienced in the management of generalized Myasthenia Gravis AND the member has tried or cannot use Vyvgart OR Vyvgart Hytrulo. Neuromyelitis Optica Spectrum Disorder (NMOSD): the member must have at least one of the core clinical characteristics associated with Neuromyelitis Optica Spectrum Disorder (NMOSD) listed below: optic neuritis, acute myelitis, area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions. The member must be anti-aquaporin-4 (AQP4) antibody positive.
Part B Prerequisite	0

BLNREP - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Blenrep (belantamab mafodotin-blmf).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member has relapsed/refractory disease AND The member has received at least two prior therapies, including a proteasome inhibitor (e.g. bortezomib) and an immunomodulatory agent (e.g. lenalidomide) AND The member is using Blenrep (belantamab mafodotin-blmf) combination with bortezomib and dexamethasone. Omission of corticosteroid from regimen is allowed if intolerance/contraindication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

bortezomib - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on bortezomib.
Required Medical Information	Mantle Cell Lymphoma (MCL): The member has a diagnosis of Mantle Cell Lymphoma(MCL). Multiple Myeloma. The member has a diagnosis of Multiple Myeloma. Waldenström's Macroglobulinemia. The member has a diagnosis of Waldenström's macroglobulinemia AND Velcade (bortezomib) is being used for primary therapy, progressive or relapsed disease or salvage therapy for disease that does not respond to primary therapy AND Velcade (bortezomib) is being used as monotherapy, in combination with Dexamethasone, or in combination with a rituximab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BORUZU - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on bortezomib.
Required Medical Information	Mantle Cell Lymphoma (MCL): The member has a diagnosis of Mantle Cell Lymphoma(MCL). Multiple Myeloma. The member has a diagnosis of Multiple Myeloma. Waldenström's Macroglobulinemia. The member has a diagnosis of Waldenström's macroglobulinemia AND Velcade (bortezomib) is being used for primary therapy, progressive or relapsed disease or salvage therapy for disease that does not respond to primary therapy AND Velcade (bortezomib) is being used as monotherapy, in combination with Dexamethasone, or in combination with a rituximab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

bosentan - TABLET

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

bosentan - TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must meet ALL of the following criteria: Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND For Brand Tracleer (tablet or tablet for suspension) and generic bosentan tablet for oral suspension requests: previous treatment, intolerance, or contraindication with bosentan tablet (generic Tracleer).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BOSULIF - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Bosulif (bosutinib). The member has one of the following mutations: T315I, V299L, G250E, or F317L.
Required Medical Information	Chronic Myelogenous Leukemia. The member has a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (CML) AND One of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated and one of the following applies: Intermediate- or high-risk score for disease progression OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib OR The member has a diagnosis of chronic phase CML that has received previous treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BRAFTOVI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic (cobimetinib), Tafinlar (dabrafenib), or Mekinist (trametinib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib)].
Required Medical Information	Melanoma - Unresectable or metastatic. The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib). Colorectal Cancer : The member has documented BRAFV600E metastatic colorectal cancer and progressive disease on prior therapy AND Braftovi (encorafenib) will be given in combination with Erbitux (cetuximab) OR The member has documented BRAFV600E metastatic colorectal cancer AND Braftovi (encorafenib) will be given in combination with Erbitux (cetuximab) and FOLFOX (fluorouracil, leucovorin, and oxaliplatin). Metastatic non-small cell lung cancer: The member has documented BRAF V600E metastatic non-small cell lung cancer (NSCLC) AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BREKIYA - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Treatment of Migraine Headaches: Brekiya will be used for acute treatment of migraine with or without aura AND Has had previous treatment, intolerance, or contraindication to Ubrelvy tablet and ONE of the following agents: naproxen tablet, naratriptan tablet, rizatriptan tablet, sumatriptan tablet, pen injector, syringe, or solution. Acute Treatment of Cluster Headaches: Brekiya will be used for acute treatment of cluster headaches AND Has had previous treatment, intolerance, or contraindication to at least TWO of the following agents: naratriptan tablet, rizatriptan tablet, sumatriptan tablet, pen injector, syringe, or solution.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

BRILINTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BRINSUPRI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-Cystic Fibrosis Bronchiectasis (NCFB): Member must have a diagnosis of non-cystic fibrosis bronchiectasis AND Diagnosis has been confirmed by chest computed tomography (CT) AND Prior to starting therapy, in the past 12 months, the member must have had: Two or more exacerbations if the member is 18 years of age and older OR One or more exacerbations if the member is 12 to 17 years of age.
Age Restriction	
Prescriber Restriction	Brinsupri (brensocatib) is prescribed by or in consultation with a pulmonologist.
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

BRIUMVI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis: The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR The member has a diagnosis of a clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), teriflunomide, or a rituximab product (e.g. Riabni, Ruxience).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

brivaracetam - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with levetiracetam AND at least ONE other drug for controlling partial-onset seizures (e.g., lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BRIVIACT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with levetiracetam AND at least ONE other drug for controlling partial-onset seizures (e.g., lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BRONCHITOL - CAPSULE, WITH INHALATION DEVICE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Cystic Fibrosis: The member must meet ALL of the following criteria: Diagnosis of Cystic Fibrosis. Deemed eligible for mannitol maintenance treatment after receiving a Bronchitol Tolerance Test (BTT) under the supervision of a healthcare practitioner. Bronchitol (mannitol) will be used in combination with a short-acting bronchodilator (e.g., albuterol).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

BRUKINSA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following Brukinsa (zanubrutinib).
Required Medical Information	Mantle cell lymphoma: The member has a diagnosis of mantle cell lymphoma AND The member has received at least one prior therapy AND The member will be using Brukinsa (zanubrutinib) as monotherapy. Marginal Zone Lymphoma: The member has a diagnosis of marginal zone lymphoma (MZL) AND The member is using Brukinsa (zanubrutinib) as second line or subsequent for refractory or progressive disease AND The member has received at least one regimen containing anti-CD20 product (e.g. rituximab product) AND The member will be using Brukinsa (zanubrutinib) as monotherapy. Waldenstroms Macroglobulinemia: The member has a diagnosis of Waldenstroms macroglobulinemia (WM) AND the member will be using Brukinsa (zanubrutinib) as monotherapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). Follicular Lymphoma: The member has a diagnosis of relapsed or refractory follicular lymphoma AND the member has had 2 or more previous lines of systemic therapy AND Brukinsa (zanubrutinib) will be used in combination with obinutuzumab.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BRYNOVIN - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

budesonide - AEROSOL, FOAM WITH APPLICATOR (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Mild to moderate active ulcerative colitis: The member must have a diagnosis of mild to moderate active ulcerative colitis AND the member must have had previous treatment or intolerance to at least two of the following: sulfasalazine, balsalazide capsules, mesalamine enema or mesalamine 0.375g extended-release.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Mild to moderate active ulcerative colitis: The member must have a diagnosis of mild to moderate active ulcerative colitis AND the member must have had previous treatment or intolerance to at least two of the following: sulfasalazine, balsalazide capsules, mesalamine enema or mesalamine 0.375g extended-release.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

budesonide - AEROSOL, FOAM WITH APPLICATOR (GRAM)

Part B Prerequisite	0

BUPHENYL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

buprenorphine - PATCH, TRANSDERMAL WEEKLY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe pain: Has persistent (non-acute) pain that requires around the clock treatment for an extended period AND Has pain severe enough to require an opioid pain medication AND previous trials of alternative treatments (e.g., non-opioid analgesics) have been inadequate AND Has had previous treatment, contraindication, or intolerance to one of the following: immediate-release opioid (i.e., oxycodone, hydromorphone, or morphine) OR extended-release opioid (i.e., oxycodone, hydromorphone, or morphine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BUTRANS - PATCH, TRANSDERMAL WEEKLY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BYLVAY - PELLETS IN DISPENSING CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Progressive familial intrahepatic cholestasis (PFIC): Member has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) with both of the following: Clinically significant cholestasis-associated pruritus as determined by the prescriber AND Elevated serum bile acids above the upper limit of normal per the lab reference normal range AND Prescribed by or in consultation with a specialist with experience treating PFIC (e.g. gastroenterologist, hepatologist) AND Has had previous treatment with or cannot use one or more of the following treatments for cholestasis-associated pruritus: ursodiol, rifampin, cholestyramine AND Does not have PFIC Type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein AND Does not have a history of portal hypertension or a hepatic decompensation event. Alagille Syndrome (ALGS): Member has a diagnosis of genetically confirmed Alagille Syndrome (ALGS) with both of the following: Clinically significant cholestasis-associated pruritus as determined by the prescriber AND Elevated serum bile acids above the upper limit of normal per the lab reference normal range AND Prescribed by or in consultation with a specialist with experience treating ALGS (e.g. gastroenterologist, hepatologist) AND Has had previous treatment with or cannot use one or more of the following treatments for cholestatic pruritus: ursodiol, rifampin, or cholestyramine AND Does not have a history of portal hypertension or a hepatic decompensation event.
Age Restriction	Progressive familial intrahepatic cholestasis (PFIC): Member is 3 months of age or older. Alagille Syndrome (ALGS): Member is 12 months of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

BYNFEZIA - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acromegaly: The member must have a diagnosis of acromegaly AND The member had inadequate response to or cannot be treated with traditional therapies including surgery and/or radiation therapy AND The member has had previous treatment or intolerance with generic subcutaneous octreotide and Sandostatin LAR Depot intramuscular susp, extended release. Treatment of Metastatic Carcinoid Tumors: Member must have a diagnosis of a carcinoid tumor AND Member must have severe diarrhea and flushing resulting from carcinoid tumor AND The member has had previous treatment or intolerance with generic subcutaneous Octreotide and Sandostatin LAR Depot intramuscular susp, extended release. Treatment of Vasoactive Intestinal Peptide Tumors (VIPomas): Member must be diagnosed with a vasoactive intestinal peptide tumor AND Member must have diagnosis of profuse watery diarrhea associated with VIPsecreting tumor AND the member has had previous treatment or intolerance with generic subcutaneous octreotide and Sandostatin LAR Depot intramuscular susp, extended release. Treatment of Chemotherapy or Radiation Induced Diarrhea: One of the following diarrhea-related conditions: Member must have = Grade 3 diarrhea according to NCI common toxicity OR Member must have NCI Grade 1 or 2 diarrhea and have had a trial with loperamide or diphenoxylate and atropine AND the member has had previous treatment or intolerance with generic subcutaneous octreotide and Sandostatin LAR Depot intramuscular susp, extended release.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Treatment of Severe Secretory Diarrhea in Acquired Immune Deficiency Syndrome (AIDS): Member must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS) AND Member must have had a trial with antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine) AND The member has had previous treatment or intolerance with generic subcutaneous octreotide and Sandostatin LAR Depot intramuscular susp, extended release.

BYNFEZIA - PEN INJECTOR (ML)

Part B Prerequisite	0

BYSTOLIC - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CABLIVI - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acquired Thrombotic Thrombocytopenic Purpura: Member has a diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) AND One of the following applies: Is receiving Cablivi in combination with plasma exchange (PEX) and immunosuppressive therapy (e.g., rituximab product) OR Is receiving Cablivi within the 30 days after PEX completion. Reauthorization: member continues to have evidence of ongoing disease (e.g. suppressed or unstable ADAMTS13 levels) AND member is still currently receiving therapy AND member has had 2 or fewer recurrences while actively receiving Cablivi.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 months duration
Other Criteria	
Part B Prerequisite	0

CABOMETYX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Hepatocellular carcinoma, Renal cell carcinoma, and Thyroid cancer: Member experiences disease progression on cabozantinib.
Required Medical Information	Renal cell carcinoma: The member has advanced renal cell carcinoma AND one of the following applies: the member will be using Cabometyx (cabozantinib) as monotherapy OR the member will be using Cabometyx (cabozantinib) in combination with Opdivo (nivolumab) as first line therapy. Hepatocellular carcinoma. The member has a diagnosis of hepatocellular carcinoma AND The member has been previously treated with a first line therapy (e.g., sorafenib) AND Cabometyx (cabozantinib) will be given as monotherapy. Thyroid Cancer: The member has a diagnosis of locally advanced or metastatic differentiated thyroid cancer AND Member has experienced disease progression following prior anti-VEGF targeted therapy AND Member is radioactive iodine refractory or ineligible AND Cabometyx (cabozantinib) will be administered as monotherapy. Neuroendocrine Tumors (NETs): The member has a diagnosis of unresectable, locally advanced, or metastatic, well-differentiated neuroendocrine tumor (i.e., pNET and epNET).
Age Restriction	Thyroid Cancer and Neuroendocrine Tumors (NETs): Member is 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CADUET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

calcipotriene - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriasis: The member must have a diagnosis of plaque psoriasis AND has had previous treatment, contraindication or intolerance with a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol cream/ointment).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

calcipotriene-betamethasone - SUSPENSION, TOPICAL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriasis: The member must have a diagnosis of plaque psoriasis AND has had previous treatment, contraindication or intolerance with a high potency corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol cream/ointment).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CALQUENCE (ACALABRUTINIB MAL) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following Calquence (acalabrutinib).
Required Medical Information	Mantle Cell Lymphoma: The member has a diagnosis of mantle cell lymphoma AND One of the following: The member has received at least one prior therapy AND the member will be using Calquence (acalabrutinib) as monotherapy OR The member has previously untreated mantle cell lymphoma AND member is ineligible for autologous hematopoietic stem cell transplantation (HSCT) AND Calquence (acalabrutinib) will be used in combination with bendamustine and a rituximab product, followed by maintenance Calquence (acalabrutinib) with or without a rituximab product. Chronic lymphocytic leukemia (CLL) / Small lymphocytic lymphoma (SLL): member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CAMCEVI (6 MONTH) - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

CAMZYOS - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Obstructive Hypertrophic Cardiomyopathy: member must have diagnosis of hypertrophic cardiomyopathy AND the member must have confirmation of an obstruction (e.g. cardiac MRI, echocardiogram, or cardiac catheterization) AND the member must have NYHA Class II-III symptoms AND the member must have a left ventricular ejection fraction (LVEF) of greater than or equal to 55% AND the member has had previous treatment, intolerance or contraindication to beta-blockers (e.g. atenolol, metoprolol, bisoprolol) or non-dihydropyridine calcium channel blockers (e.g. verapamil, diltiazem) at doses appropriate for obstructive hypertrophic cardiomyopathy. Reauthorization criteria: the member must meet all of the following criteria: the member must have a LVEF greater than or equal to 50% AND the member has had clinically significant improvement of symptoms (e.g. improvement in NT-proBNP, decreased shortness of breath, improvement in patient reported outcomes assessment) AND provider attestation that the patient has not and will not receive septal reduction therapy (SRT) while on mavacamten therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial Duration: 6 Months. Reauthorization: Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CANCIDAS - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CAPLYTA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia. The member must have a diagnosis of schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to at least two of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I or II Disorder (Bipolar Depression): The member must have a diagnosis of bipolar I or II disorder (bipolar depression) AND the member must have documentation of prior therapy, intolerance, or contraindication to quetiapine and at least one of the following: olanzapine, or lurasidone. Major Depressive Disorder: The member has a clinical diagnosis of major depressive disorder (MDD) AND The member has had previous treatment, contraindication, or intolerance to at least one antidepressant used as monotherapy for MDD AND The member has had previous treatment, contraindication, or intolerance to at least one generic atypical antipsychotic therapy that has been used as an adjunct (i.e., add-on) to antidepressant therapy AND Caplyta (lumateperone) will be used as adjunctive treatment to antidepressant therapy and not as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CAPRELSA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Vandetanib.
Required Medical Information	Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic medullary thyroid cancer AND The member has symptomatic or progressive disease OR the member has a diagnosis of symptomatic iodine refractory follicular carcinoma or oncocytic carcinoma or papillary carcinoma AND unresectable recurrent or persistent locoregional disease or metastatic disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CARAC - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CARBAGLU - TABLET, DISPERSIBLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute or chronic hyperammonemia due to NAGS deficiency: the member has acute or chronic hyperammonemia due to deficiency of hepatic enzyme N-acetylglutamate synthase (NAGS). Acute hyperammonemia due to PAA or MMA deficiency: the member has acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CARDAMYST - SPRAY, NON-AEROSOL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has heart failure NYHA Class II-IV (e.g. fatigue, palpitations, or shortness of breath with ordinary activities, symptoms with less than ordinary activity, or symptoms at rest).
Required Medical Information	Paroxysmal Supraventricular Tachycardia (PSVT): Must have a diagnosis of paroxysmal supraventricular tachycardia (PSVT) AND Member has a history of sustained PSVT episodes (e.g. episodes lasting more than 20 minutes) AND Previous treatment, contraindication, or intolerance to oral calcium channel blockers (e.g. diltiazem, verapamil) OR beta-blockers (e.g. propranolol).
Age Restriction	
Prescriber Restriction	Prescribed by or in consultation with a specialist in PSVT management (e.g. cardiologist).
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

CARDIZEM CD - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

carglumic acid - TABLET, DISPERSIBLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute or chronic hyperammonemia due to NAGS deficiency: the member has acute or chronic hyperammonemia due to deficiency of hepatic enzyme N-acetylglutamate synthase (NAGS). Acute hyperammonemia due to PAA or MMA deficiency: the member has acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CAYSTON - VIAL, NEBULIZER (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients with a forced expiratory volume in one second (FEV1) less than 25% or greater than 75% predicted. Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis. The member must have a diagnosis of cystic fibrosis (CF). The member is colonized with Pseudomonas aeruginosa. The member must have a short or long-acting beta-agonist bronchodilator (e.g. albuterol or formoterol), and will be utilized prior to Cayston.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year duration
Other Criteria	
Part B Prerequisite	0

CELEBREX - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CELEXA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CEQUA - DROPPERETTE, SINGLE-USE DROP DISPENSER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dry eye disease. Has a diagnosis of dry eye disease AND has had previous treatment, contraindication, or intolerance to the following: cyclosporine eye drops (generic Restasis), AND Eysuvis (loteprednol)*. *Previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CERDELGA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 1 Gaucher's disease: The member has a diagnosis of type 1 Gaucher's disease AND Member is a CYP2D6 poor metabolizer (PM), extensive metabolizer (EM), or intermediate metabolizer (IM) as confirmed by an FDA-approved genetic test AND Previous treatment with, contraindication to, or intolerance with Elelyso (taliglucerase alfa).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CEREZYME - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 1 Gaucher disease: Member is using for treatment of non-central nervous system (CNS) manifestations of Type 1 Gaucher disease AND Previous treatment with, contraindication to, or intolerance with Elelyso (taliglucerase alfa). Type 3 Gaucher disease: Member is using for treatment of non-central nervous system (CNS) manifestations of Type 3 Gaucher disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CHANTIX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CHANTIX CONTINUING MONTH BOX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CHANTIX STARTING MONTH BOX - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

chenodal - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Pre-existing liver disease.
Required Medical Information	The member has a diagnosis of radiolucent gallstones in well-opacifying gallbladders AND the member is not a candidate for laparoscopic cholecystectomy AND the member must have had previous treatment with, contraindication, or intolerance to ursodiol.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

CHORIONIC GONADOTROPIN, HUMAN - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Obesity, Female or male infertility, Erectile Dysfunction, Precocious puberty, Prostatic carcinoma or other androgen-dependent neoplasm.
Required Medical Information	NA
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

CIALIS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Benign Prostatic Hyperplasia (BPH). The member has a diagnosis of benign prostatic hyperplasia (BPH). The member has failed previous treatment or has a contraindication/intolerance to an alpha blocker (i.e. terazosin, doxazosin, tamsulosin, alfuzosin) AND a 5-alpha reductase inhibitor (i.e. finasteride, dutasteride).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CIBINQO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: The member has diagnosis of moderate to severe atopic dermatitis AND the member has had prior therapy, contraindication, or intolerance with Dupixent and Rinvoq.
Age Restriction	The member is 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CIMZIA - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Crohn's Disease: The member must have a diagnosis of moderate to severely active Crohn's disease. The member must have had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Psoriatic Arthritis: Must have a diagnosis of active psoriatic arthritis: The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis and the member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Plaque Psoriasis. The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	The member must be 18 years of age or older for Crohn's Disease, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, and Plaque Psoriasis. The member must be 2 years of age or older for Polyarticular Juvenile Idiopathic Arthritis (PJIA).
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CIMZIA - SYRINGE KIT (EA)

Other Criteria	Non-Radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member had had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis AND The member must have had prior therapy, contraindication, or intolerance to two of the following: a preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq.
Part B Prerequisite	0

CIMZIA POWDER FOR RECONST - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Crohn's Disease: The member must have a diagnosis of moderate to severely active Crohn's disease. The member must have had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Psoriatic Arthritis: Must have a diagnosis of active psoriatic arthritis: The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis and the member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Plaque Psoriasis. The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	The member must be 18 years of age or older for Crohn's Disease, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, and Plaque Psoriasis. The member must be 2 years of age or older for Polyarticular Juvenile Idiopathic Arthritis (PJIA).
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CIMZIA POWDER FOR RECONST - KIT

Other Criteria	Non-Radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member had had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis AND The member must have had prior therapy, contraindication, or intolerance to two of the following: a preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq.
Part B Prerequisite	0

CIMZIA STARTER KIT - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Crohn's Disease: The member must have a diagnosis of moderate to severely active Crohn's disease. The member must have had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Psoriatic Arthritis: Must have a diagnosis of active psoriatic arthritis: The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Ankylosing Spondylitis: The member has a diagnosis of ankylosing spondylitis and the member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Plaque Psoriasis. The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	The member must be 18 years of age or older for Crohn's Disease, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, and Plaque Psoriasis. The member must be 2 years of age or older for Polyarticular Juvenile Idiopathic Arthritis (PJIA).
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CIMZIA STARTER KIT - SYRINGE KIT (EA)

Other Criteria	Non-Radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member had had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis AND The member must have had prior therapy, contraindication, or intolerance to two of the following: a preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq.
Part B Prerequisite	0

CINQAIR - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Severe Asthma with an Eosinophilic Phenotype: The member has a diagnosis of severe asthma AND the member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of greater than or equal to 150 cells/microliter at therapy initiation OR greater than or equal to 300 cells/microliter in the previous 12 months. The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta agonist (e.g. formoterol). Eosinophilic Granulomatosis with Polyangiitis (EGPA) - Nucala and Fasenra only: The member has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the member has a baseline elevated peripheral blood eosinophil level of greater than 10% of total leukocyte count AND The member has been unable to achieve adequate control of EGPA while on oral corticosteroid therapy (e.g. prednisone, methylprednisolone). Hypereosinophilic Syndrome (HES) - Nucala only: The member has a diagnosis of hypereosinophilic syndrome (HES) for at least 6 months AND The member has a baseline blood eosinophil level of greater than or equal to 1000 cells/microliter.
Age Restriction	Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CINQAIR - VIAL (ML)

Other Criteria	Chronic Rhinosinusitis with Nasal Polyposis - Nucala Only: The member must meet ALL of the following criteria: Diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Nucala (mepolizumab) will be used in conjunction with a daily intranasal corticosteroid spray AND member is unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) AND Member has an eosinophilic phenotype defined as an elevated peripheral blood eosinophil level of the following before therapy is started: greater than or equal to 150 cells/microliter OR greater than or equal to 300 cells/microliter in the previous 12 months. Member has been unable to achieve adequate control of COPD while on an: Inhaled corticosteroid therapy in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) OR LABA-LAMA therapy if inhaled corticosteroids are contraindicated.
Part B Prerequisite	0

CINRYZE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Prophylaxis: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member is using Cinryze for prophylaxis to prevent attacks of HAE. The member has had previous treatment, contraindication or intolerance with an appropriately dosed Haegarda for HAE prophylaxis. Documentation details must be submitted for one of the following: trial of Haegarda and the member's response, member's specific contraindication to Haegarda, OR describing the side effects observed with Haegarda.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CINVANTI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of Chemotherapy-induced nausea and vomiting: Is using for prophylaxis (and not for treatment) of chemotherapy-induced nausea and vomiting AND The member is receiving highly emetogenic chemotherapy (HEC) or moderately emetogenic chemotherapy (MEC) AND One of the following applies: Is taking as part of an antiemetic regimen that includes both a corticosteroid (e.g., dexamethasone) and a 5-HT3 antagonist (ondansetron, dolasetron, palonosetron, or granisetron) OR Has a contraindication to corticosteroids or 5-HT3 antagonists.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

cladribine(multiple sclerosis) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	More than 2 treatment courses within a 2 year period.
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease AND All of the following have been ruled out before starting Mavenclad (cladribine): current malignancy, human immunodeficiency virus (HIV) infection, active hepatitis, active tuberculosis AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CLARINEX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

clemastine - SYRUP

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Allergic Rhinitis. Has a diagnosis of allergic rhinitis AND has had previous treatment, intolerance, or contraindication to TWO of the following agents: cetirizine oral solution/syrup, fluticasone propionate nasal spray, levocetirizine tablet. Urticaria: Diagnosis of allergic skin manifestations of urticaria and angioedema AND has had previous treatment, intolerance, or contraindication to a second generation antihistamine (e.g. desloratadine tablet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

CLEOCIN - CREAM WITH APPLICATOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CLINDAGEL - GEL, ONCE DAILY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has a diagnosis of acne vulgaris AND has had previous treatment or intolerance with two of the following topical products: adapalene gel, clindamycin gel (generic Ceocin-T gel)/ lotion/solution/pledgets* or erythromycin solution. *Clindamycin gel/lotion/solution have additional prior authorization requirements.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

clindamycin phosphate - GEL, ONCE DAILY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has a diagnosis of acne vulgaris AND has had previous treatment or intolerance with two of the following topical products: adapalene gel, clindamycin gel (generic Ceocin-T gel)/ lotion/solution/pledgets* or erythromycin solution. *Clindamycin gel/lotion/solution have additional prior authorization requirements.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

clobazam - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND Onfi (clobazam) will be used in combination with at least one other drug for controlling seizures AND The member has been unable to achieve seizure control with at least one other drug used for the adjunctive treatment of Lennox-Gastaut syndrome (e.g., lamotrigine, rufinamide, topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

clonidine hcl - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hypertension: The member must have a diagnosis of hypertension AND the member has had previous treatment, intolerance, or contraindication to clonidine hcl immediate-release tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

clozapine - TABLET,DISINTEGRATING

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must be using clozapine ODT or Versacloz (clozapine oral solution) for treatment-resistant schizophrenia. The member must have had prior therapy or intolerance to generic clozapine tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

COBENFY - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Urinary retention. Moderate or severe hepatic impairment. Gastric retention. Untreated narrow-angle glaucoma.
Required Medical Information	Schizophrenia: The member will be using Cobenfy for the treatment of schizophrenia AND The member has tried or cannot use at least two of the following generic atypical antipsychotics: olanzapine, risperidone, aripiprazole, quetiapine, lurasidone, or ziprasidone.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COBENFY STARTER PACK - CAPSULE, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Urinary retention. Moderate or severe hepatic impairment. Gastric retention. Untreated narrow-angle glaucoma.
Required Medical Information	Schizophrenia: The member will be using Cobenfy for the treatment of schizophrenia AND The member has tried or cannot use at least two of the following generic atypical antipsychotics: olanzapine, risperidone, aripiprazole, quetiapine, lurasidone, or ziprasidone.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COLAZAL - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

colchicine - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of gout flares. The member has a diagnosis of gout AND The member will be using colchicine products for the prophylaxis of gout flares AND The member will be using concomitant or has a contraindication to urate lowering therapy AND The member has had previous treatment failure with colchicine tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

COLCRYS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of gout flares. The member has a diagnosis of gout AND The member will be using colchicine products for the prophylaxis of gout flares AND The member will be using concomitant or has a contraindication to urate lowering therapy AND The member has had previous treatment failure with colchicine tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

COLUMVI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member experienced disease progression on Columvi (glofitamab-gxbm) CD20-directed CD3 T-cell engager.
Required Medical Information	Large B-cell Lymphoma (relapsed/refractory): The member has a diagnosis of diffuse large B-cell lymphoma, not otherwise specified (DLBCL, NOS) OR large B-cell lymphoma (LBCL) arising from follicular lymphoma AND the member has received two or more prior lines of systemic therapy AND Columvi (glofitamab-gxbm) will be used as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COMETRIQ - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Cometriq (cabozantinib).
Required Medical Information	Metastatic Medullary Thyroid Carcinoma. The member has a diagnosis of progressive, metastatic medullary thyroid carcinoma MTC.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CONCERTA - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

COPAXONE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

COPIKTRA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib, duvelisib).
Required Medical Information	Chronic lymphocytic leukemia. The member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) AND the member has relapsed or refractory disease AND The member will be using Copiktra (duvelisib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COREG - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

COREG CR - CAPSULE,EXTENDED RELEASE MULTIPHASE 24HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CORLANOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Heart rate maintained exclusively by pacemaker.
Required Medical Information	Heart Failure (Adult Patients): The member must meet ALL of the following criteria: have a diagnosis of NYHA Class II, III, or IV heart failure AND Documentation of left ventricular ejection fraction less than or equal to 35% AND The member must be in sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute AND Documentation of blood pressure greater than or equal to 90/50 mmHg AND Documentation of previous treatment, intolerance, or contraindication to maximally tolerated doses of at least one beta-blocker (e.g., carvedilol 50 mg daily, metoprolol 200 mg daily, or bisoprolol 10 mg daily) AND In patients with Severe Hepatic Impairment (Child-Pugh Class C) - Provider attests that the risk versus benefit of severe hypotension has been considered, and the benefits of treatment outweigh the risks. Heart Failure (Pediatric Patients) The member must meet ALL of the following criteria: The member must have a diagnosis of NYHA Class II, III, or IV heart failure AND Documentation of left ventricular ejection fraction less than or equal to 45% AND The member has been clinically stable for at least 4 weeks AND The member is in sinus rhythm AND In patients with Severe Hepatic Impairment (Child-Pugh Class C) - Provider attests that the risk versus benefit of severe hypotension has been considered, and the benefits of treatment outweigh the risks AND One of the following: The member is 6 to 12 months of age and has a resting heart rate of greater than or equal to 105 beats per minute OR The member is 1 to less than 3 years of age and has a resting heart rate of greater than or equal to 95 beats per minute OR The member is 3 to less than 5 years of age and has a resting heart rate of greater than or equal to 75 beats per minute OR The member is greater than 5 years of age and has a resting heart rate of greater than or equal to 70 beats per minute.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Reauthorization Criteria (Adult and Pediatric Patients): Member has continued clinical benefit from Corlanor (ivabradine) as defined by maintenance of decreased Heart rate compared to initiation of Corlanor (ivabradine) treatment.

CORLANOR - TABLET

Part B Prerequisite	0

CORTROPHIN GEL - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	West syndrome (infantile spasms): Member has a diagnosis of West Syndrome (infantile spasms) AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of West Syndrome (e.g., neurologist, epileptologist). Acute exacerbation of multiple sclerosis (MS): The member is experiencing an acute exacerbation of multiple sclerosis (MS) AND The member is currently taking a disease-modifying treatment (DMT) for MS (e.g., dimethyl fumarate, fingolimod, teriflunomide, a glatiramer product, etc.) unless at least one of the following applies: This is the member's first clinical episode of MS (i.e., clinically isolated syndrome [CIS]), The provider attests that use of any disease-modifying treatment for MS is inappropriate for the individual member AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of multiple sclerosis (e.g., neurologist) AND One of the following applies: The member has failed a recent (within the last 30 days) trial of at least a 3-day course of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone) for an acute exacerbation of MS. Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects.
Age Restriction	West syndrome (infantile spasms): Member is less than 2 years old.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CORTROPHIN GEL - VIAL (ML)

Other Criteria	Acute exacerbation of rheumatic disorders, collagen diseases, ophthalmic diseases, nephrotic syndrome or other steroid-responsive conditions: The member is experiencing an acute exacerbation of one of the following: A rheumatic disorder (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis) OR A collagen disease (e.g., systemic lupus erythematosus, systematic dermatomyositis) OR An ophthalmic disease (e.g., keratitis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation) OR Nephrotic syndrome OR Other steroid-responsive condition AND One of the following applies: The member has failed a trial of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone) for their condition. Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects. Symptomatic sarcoidosis: The member has a diagnosis of sarcoidosis AND Repository corticotropin is prescribed by or in consultation with a provider experienced in the treatment of sarcoidosis (e.g., rheumatologist, pulmonologist, cardiologist) AND One of the following applies: The member has failed a trial of corticosteroid therapy (e.g., dexamethasone, methylprednisolone, prednisone). Documentation must be submitted detailing the trial of corticosteroids and the member's response OR The member has experienced serious and intolerable side effects (e.g., severe hyperglycemia) with a corticosteroid. Documentation must be submitted describing the side effects observed OR The member has a contraindication to all corticosteroids. Documentation must be submitted describing the member's contraindication AND The member has tried at least one other medication, either in combination with or as an alternative to corticosteroids, for the treatment of sarcoidosis (e.g., methotrexate, azathioprine, infliximab, adalimumab) AND The provider attests that repository corticotropin injection is not expected to be associated with the same contraindications and/or side effects seen with corticosteroids, despite its steroid-like effects.
Part B Prerequisite	0

COSENTYX - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COSENTYX - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Combination therapy with other biologics (e.g. Cosentyx, Enbrel, adalimumab product, Kevzara, Remicade).
Required Medical Information	Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, contraindication, or intolerance with: Remicade, Inflectra, Infliximab OR Simponi Aria* (*Prior therapy with Simponi Aria applies to medical benefits only). Ankylosing Spondylitis: The member must have a diagnosis of active ankylosing spondylitis AND The member has had prior therapy, contraindication, or intolerance with one of the following: Remicade, Inflectra, Infliximab OR Simponi Aria* (*Prior therapy with Simponi Aria applies to medical benefits only). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx SQ or Rinvoq.
Age Restriction	The member must be at least 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COSENTYX (2 SYRINGES) - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COSENTYX PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COSENTYX PEN (2 PENS) - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COSENTYX UNOREADY PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. Active ankylosing spondylitis: The member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Active Enthesitis-related Juvenile Idiopathic Arthritis: The member has a diagnosis of active enthesitis-related arthritis (ERA) AND the member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAID) (e.g. ibuprofen, meloxicam, naproxen). Hidradenitis suppurativa: The member must have a diagnosis of moderate to severe hidradenitis suppurativa.
Age Restriction	Plaque Psoriasis: Member must be 6 years of age or older. Ankylosing Spondylitis, Non-radiographic axial spondyloarthritis, and Hidradenitis suppurativa: Member must be 18 years of age or older. Psoriatic Arthritis: member must be 2 years of age or older. Active Enthesitis-related Juvenile Idiopathic Arthritis: member must be 4 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

COTELLIC - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Melanoma indication only: Members on Cotellic as a single agent. Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Tafenlar (dabrafenib), Mekinist (trametinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Cotellic. Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g., Braftovi (encorafenib) with Mektovi (binimetinib) or Tafenlar (dabrafenib) with Mekinist (trametinib)].
Required Medical Information	Melanoma: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Cotellic (cobimetinib) in combination with Zelboraf (vemurafenib). Histiocytic Neoplasms: the member has a diagnosis of histiocytic neoplasms AND the member will be using Cotellic (cobimetinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

COZAAR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CRENESSITY - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Congenital adrenal hyperplasia (CAH): Member has a diagnosis of classic congenital adrenal hyperplasia (CAH) AND Member will continue chronic glucocorticoid replacement therapy associated with CAH (e.g., dexamethasone, hydrocortisone, methylprednisolone).
Age Restriction	
Prescriber Restriction	Prescribed by or in consultation with an endocrinologist or provider who specializes in the treatment of adrenal hyperplasia.
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

CRESEMBA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Familial short QT syndrome.
Required Medical Information	Invasive Aspergillosis and Invasive Mucormycosis: Member must have diagnosis of invasive aspergillosis or invasive mucormycosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CRESTOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

crotan - LOTION (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Scabies. Member must have a diagnosis of scabies AND Has had previous treatment, contraindication or intolerance to permethrin 5% cream AND oral ivermectin. Pruritic Skin. Member must be using to treat pruritis of the skin AND Has had previous treatment, contraindication, or intolerance to a topical corticosteroid (e.g. hydrocortisone, triamcinolone, mometasone) AND an oral antihistamine (e.g. hydroxyzine, levocetirizine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CRYSVITA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	X-Linked Hypophosphatemia (XLH): Initial approval: Member must have diagnosis of XLH supported by both of the following: Serum fibroblast growth factor 23 (FGF23) level greater than 30 pg/mL OR a positive PHEX test AND a reduction in the ratio of the maximum rate of tubular phosphate reabsorption to the glomerular filtration rate (TmP/GFR). Member must have clinical signs and symptoms of XLH (e.g. rickets, growth impairment, musculoskeletal pain, fractures). Tumor-Induced Osteomalacia (TIO) - Initial Approval: The member must have a diagnosis of FGF23-related hypophosphatemia in tumor-induced osteomalacia supported by BOTH of the following: Serum fibroblast growth factor 23 (FGF23) level of greater than 30 pg/mL AND A reduction in the ratio of the maximum rate of tubular phosphate reabsorption to the glomerular filtration rate (TmP/GFR) AND The disease must be associated with phosphaturic mesenchymal tumors AND The disease cannot be curatively resected or localized AND The member must have clinical signs and symptoms of TIO (muscle weakness, skeletal weakness, muscle pain, fatigue, hypophosphatemia).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CTEXLI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cerebrotendinous Xanthomatosis (CTX): Diagnosis of cerebrotendinous xanthomatosis (CTX) that has been confirmed via genetic testing that shows a variant in the CYP27A1 gene AND Member is being treated by or in consultation with a specialist (e.g. neurologist, endocrinologist, metabolic specialists, etc.).
Age Restriction	Member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

CUPRIMINE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Wilson's Disease: The member has a diagnosis of Wilson's Disease confirmed by one of the following: presence of Kayser-Fleischer rings and low serum ceruloplasmin (CPN), molecular generic confirmation OR liver biopsy confirmation AND has had previous treatment or intolerance with generic penicillamine tablet. Cystinuria: The member has a diagnosis of cystinuria AND will be using in combination with all the following preventative measures unless there is a contraindication or intolerance to their use: high fluid intake (i.e. at least 2.5 liters daily), elevation of urine pH with potassium citrate and dietary modifications (i.e. limited sodium and protein intake) AND has previously been unresponsive to these preventative measures alone or has a contraindication or intolerance to their use AND has had previous treatment or intolerance with generic penicillamine tablet. Rheumatoid arthritis: The member has a diagnosis of rheumatoid arthritis AND has had previous treatment or intolerance with one of the following conventional treatments: hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine AND has had previous treatment or intolerance with generic penicillamine tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CUTAQUIG - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CUTAQUIG - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

CUVRIOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Wilson's Disease: Member has a diagnosis of Wilson's disease confirmed by one of the following: Presence of Kayser-Fleischer rings and low Serum ceruloplasmin (CPN) levels and elevated 24 hour urinary copper levels OR Molecular genetic confirmation OR Liver biopsy confirmation AND Member has completed initial treatment with a chelator (e.g. penicillamine) to remove accumulated copper (i.e. has been "de-coppered") AND Member has tried and is able to tolerate penicillamine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

CYKLOKAPRON - AMPUL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with acquired defective color vision, since this prohibits measuring one endpoint that should be followed as a measure of toxicity (changes in vision).Members with subarachnoid hemorrhage. Members with active intravascular clotting.
Required Medical Information	Hemophilia-Hemorrhage.Prophylaxis for Tooth extraction.Members with Hemophilia undergoing dental extraction.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	30 day duration
Other Criteria	NA
Part B Prerequisite	0

CYLTEZO(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CYLTEZO(CF) - SYRINGE KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

CYLTEZO(CF) PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CYLTEZO(CF) PEN - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

CYLTEZO(CF) PEN CROHN'S-UC-HS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CYLTEZO(CF) PEN CROHN'S-UC-HS - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

CYLTEZO(CF) PEN PSORIASIS-UV - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

CYLTEZO(CF) PEN PSORIASIS-UV - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

CYMBALTA - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CYRAMZA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Cyramza (ramucirumab).
Required Medical Information	Gastric Cancer: member has a diagnosis of advanced or metastatic gastric cancer or gastro-esophageal adenocarcinoma AND the member has disease progression or intolerance on or after prior therapy with platinum-based or fluoropyrimidine-based chemotherapy AND Cyramza (ramucirumab) will be used as subsequent therapy AND will be used as monotherapy or in combination with paclitaxel. Non-Small Cell Lung Cancer: The member has a diagnosis of metastatic non-small cell lung cancer AND The member has disease progression or intolerance on or after prior therapy with platinum-based chemotherapy AND For members with EGFR (epidermal growth factor receptor) or ALK (anaplastic lymphoma kinase) genomic aberrations: the member has disease progression on FDA-approved therapy for these aberrations and Cyramza will be used in combination with Docetaxel OR member has documented epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) mutations AND Cyramza (ramucirumab) is given in combo with erlotinib as first line therapy. Colorectal Cancer: The member has a diagnosis of unresectable or metastatic colorectal cancer AND Cyramza (ramucirumab) will be given as primary treatment in combination with irinotecan or FOLFIRI (fluorouracil, leucovorin calcium, and irinotecan) for unresectable metachronous metastases and previous treatment with FOLFOX (fluorouracil, leucovorin calcium, and oxaliplatin) or CapeOX (capecitabine, oxaliplatin) as adjuvant therapy has been given OR The member has disease progression on or after prior therapy with a bevacizumab product, oxaliplatin, and a fluoropyrimidine (e.g. 5-fluorouracil, capecitabine) AND Cyramza is given in combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil) or irinotecan as therapy after first progression of disease if irinotecan was not previously given.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration

CYRAMZA - VIAL (ML)

Other Criteria	Esophageal Cancer: The member has a diagnosis of unresectable locally advanced, recurrent, or metastatic esophageal adenocarcinoma AND Cyramza will be used as second or subsequent line therapy with or without paclitaxel. Hepatocellular Carcinoma: The member has a diagnosis of metastatic or unresectable hepatocellular carcinoma AND the member has received prior treatment with a first line therapy (e.g.,sorafenib) AND the member has alpha fetoprotein greater than or equal to 400 ng/ml AND Cyramza (ramucirumab) will be given as a single agent as subsequent therapy.
Part B Prerequisite	0

CYSTADANE - POWDER (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

CYSTADROPS - DROPS

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Cystinosis: The member has a diagnosis of cystinosis AND The member is using cysteamine ophthalmic solution in the treatment of corneal cystine crystal accumulation.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

CYSTARAN - DROPS

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Cystinosis: The member has a diagnosis of cystinosis AND The member is using cysteamine ophthalmic solution in the treatment of corneal cystine crystal accumulation.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

CYTOGAM - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with selective immunoglobulin A deficiency.
Required Medical Information	Cytomegalovirus infection.Prophylaxis.Transplantation of heart, liver, pancreas, kidney, lung: Member is CMV seronegative. Organ donor is CMV seropositive.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	
Part B Prerequisite	0

dalfampridine - TABLET, EXTENDED RELEASE 12 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	History of seizure disorder. Moderate to severe renal impairment (CrCl 50ml/min or less).
Required Medical Information	Multiple Sclerosis: Member has a diagnosis of multiple sclerosis AND Patient must be ambulatory AND The member has evidence of significant walking impairment related to multiple sclerosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DALIRESP - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DANYELZA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members receiving Danyelza (naxitamab) as monotherapy. Members that have experienced disease progression while on Danyelza (naxitamabgqgk).
Required Medical Information	Relapsed or Refractory Neuroblastoma: The member has a diagnosis of relapsed or refractory high-risk neuroblastoma AND The disease is in the bone or bone marrow AND The member has achieved a partial or minor response or stable disease to prior therapy AND Danyelza (naxitamab-gqgk) will be used in combination with Leukine (sargramostim).
Age Restriction	The member is 1 year of age and older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DANZITEN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression on any nilotinib (e.g. Tasigna, Danziten).
Required Medical Information	Pending CMS Review
Age Restriction	The member is 18 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

DARAPRIM - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DARZALEX - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression while taking Darzalex (daratumumab).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member will be using Darzalex (daratumumab) for newly diagnosed disease AND the member is ineligible for autologous stem cell transplant AND the member will be using Darzalex (daratumumab) in combination with bortezomib, melphalan, and prednisone OR the member will be using Darzalex in combination with lenalidomide and dexamethasone OR the member is eligible for autologous stem cell transplant AND the member will be using Darzalex in combination with bortezomib, thalidomide, and dexamethasone OR the member will be using Darzalex (daratumumab) for relapsed, progressive, or refractory disease in one of the following scenarios: The member will be using Darzalex (daratumumab) in combination with Pomalyst (pomalidomide) and dexamethasone AND the member has received at least two prior therapies, including lenalidomide and a proteasome inhibitor (e.g. bortezomib, carfilzomib, or ixazomib) OR The member will be using Darzalex (daratumumab) in combination with Velcade (bortezomib) and dexamethasone OR The member will be using Darzalex (daratumumab) in combination with Revlimid (lenalidomide) and dexamethasone OR the member will be using Darzalex (daratumumab) in combination with Kyprolis (carfilzomib) OR The member will be using Darzalex (daratumumab) as monotherapy and one of the following applies: The member has received at least three prior lines of therapy, which must have included a proteasome inhibitor (e.g. bortezomib or carfilzomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide) OR The member is double-refractory to a proteasome inhibitor (e.g. bortezomib or carfilzomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide). Omission of corticosteroid from regimen is allowed if intolerance/contraindication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DARZALEX FASPRO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression while taking daratumumab. Members who have NYHA Class IIIB or Class IV cardiac disease or Mayo Stage IIIB (Applicable to Light chain (AL) amyloidosis indication only).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member will be using Darzalex (daratumumab) Faspro for newly diagnosed disease in one of the following scenarios AND the member is ineligible for autologous stem cell transplant AND the member will be using Darzalex Faspro in combination with bortezomib, melphalan, and prednisone OR the member will be using Darzalex Faspro in combination with lenalidomide and dexamethasone OR the member will be using Darzalex Faspro in combination with bortezomib, lenalidomide and dexamethasone the member is eligible for autologous stem cell transplant AND the member will be using in combination with bortezomib, thalidomide, and dexamethasone OR the member will be using in combination with bortezomib, lenalidomide, and dexamethasone OR the member will be using Darzalex Faspro for relapsed or progressive disease in one of the following scenarios: in combination with Velcade (bortezomib) and dexamethasone OR in combination with Kyprolis (carfilzomib) and dexamethasone OR in combination with Revlimid (lenalidomide) and dexamethasone OR in combination with Pomalyst (pomalidomide) and dexamethasone OR as monotherapy and one of the following applies: The member has received at least three prior lines of therapy, which must have included a proteasome inhibitor (e.g. bortezomib or carfilzomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide) OR The member is double-refractory to a proteasome inhibitor (e.g. bortezomib or carfilzomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide). Omission of corticosteroid from regimen is allowed if intolerance/contraindication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

DARZALEX FASPRO - VIAL (ML)

Other Criteria	Light Chain Amyloidosis: The member has a diagnosis of light chain amyloidosis AND The member will be using Darzalex Faspro for newly diagnosed disease AND The member will be using in combination with bortezomib, cyclophosphamide, and dexamethasone. Omission of corticosteroid from regimen is allowed if intolerance/contraindication. Smoldering Multiple Myeloma: The member has a diagnosis of smoldering multiple myeloma AND The member's disease is categorized as high-risk*. *e.g. According to the Mayo 2018 & International Myeloma Working Group (IMWG) 20/2/20 criteria, high risk is defined as the presence of at least two of the following: serum M-protein greater than 2 g/dL OR bone marrow plasma cells greater than 20% OR free light chain ratio greater than 20. The member will be using Darzalex Faspro as monotherapy.
Part B Prerequisite	0

dasatinib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on dasatinib. For ALL and CML: The member has one of the following mutations: T315I/A, F317L/V/I/C or V299L.
Required Medical Information	Chronic Myelogenous Leukemia (CML): The member has a diagnosis of Ph+ chronic myeloid leukemia (CML) and one of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated and one of the following applies: Intermediate- or high-risk score for disease progression OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib OR The member has a diagnosis of chronic phase CML that has received previous treatment AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. Acute Lymphoblastic Leukemia (ALL): The member has ALL (Philadelphia Chromosome positive) and dasatinib is being used for induction or consolidation treatment in combination with chemotherapy or corticosteroids OR treatment is for maintenance therapy or the treatment of members with resistance or intolerance to prior therapy AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. Advanced Gastrointestinal Stromal Tumor (GIST): The member has a diagnosis of advanced unresectable GIST. The member has progressive disease or is intolerant to prior therapy with imatinib or sunitinib or Stivarga (regorafenib) AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

dasatinib - TABLET

Other Criteria	[Pediatric] Chronic Myelogenous Leukemia (CML). The member has a diagnosis of chronic myeloid leukemia (CML) that is Philadelphia chromosome positive (Ph+) AND the member is in chronic phase AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. [Pediatric] Acute lymphoblastic leukemia (ALL). The member has a diagnosis of acute lymphoblastic leukemia (ALL) AND the member has Philadelphia chromosome positive (Ph+) disease AND the member has newly-diagnosed disease AND The member will be using dasatinib in combination with chemotherapy AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib.
Part B Prerequisite	0

DATROWAY - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on prior Datroway (datopotamab deruxtecan-dlnk).
Required Medical Information	Breast Cancer [HR-positive and HER2-negative]: The member has a diagnosis of unresectable or metastatic, hormone receptor [HR]-positive, human epidermal growth factor receptor 2 [HER2]-negative (IHC 0, IHC 1+ or IHC 2+/ISH-) breast cancer AND The member has received prior endocrine-based therapy AND The member has received at least one line of prior systemic chemotherapy in the unresectable or metastatic setting AND Datroway (datopotamab deruxtecan-dlnk) will be given as monotherapy. Non-Small Cell Lung Cancer (NSCLC) [EGFR-mutated]: The member has a diagnosis of locally advanced or metastatic, non-squamous, non-small cell lung cancer (NSCLC) AND The disease is documented as epidermal growth factor receptor (EGFR)-mutated (e.g., EGFR exon 19 deletion and L858R) AND The member has received prior EGFR-directed therapy (e.g., osimertinib) and platinum-based chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

DAURISMO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Daurismo (glasdegib).
Required Medical Information	Acute Myeloid Leukemia. The member has a diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND One of the following applies: The member is age 75 years or older OR The member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. severe cardiac disease, baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2, or baseline serum creatinine greater than 1.3 mg/dL) AND The member will be using Daurismo (glasdegib) in combination with low-dose Cytarabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DAWNZERA - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Prophylaxis: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2 AND The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND other potential causes of angioedema have been ruled out or considered AND The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist) AND Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member is using Dawnzera for prophylaxis to prevent attacks of HAE AND The member has had previous treatment, contraindication or intolerance with an appropriately dosed Haegarda for HAE prophylaxis. Documentation details must be submitted for one of the following: trial of Haegarda and the member's response, member's specific contraindication to Haegarda, OR describing the side effects observed with Haegarda.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

DAYBUE - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rett Syndrome: Member has a diagnosis of Rett Syndrome AND If the member is taking laxatives, the laxatives will be stopped or decreased before starting Daybue (trofinetide) AND Kidney function tests have been completed to rule out severe renal impairment (eGFR less than 30 mL/min/1.73m ²).
Age Restriction	
Prescriber Restriction	Prescribed by or in consultation with a provider experienced in the diagnosis and management of Rett Syndrome (e.g. neurologist, pediatric neurologist).
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DAYBUE STIX - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rett Syndrome: Member has a diagnosis of Rett Syndrome AND If the member is taking laxatives, the laxatives will be stopped or decreased before starting Daybue (trofinetide) AND Kidney function tests have been completed to rule out severe renal impairment (eGFR less than 30 mL/min/1.73m ²).
Age Restriction	
Prescriber Restriction	Prescribed by or in consultation with a provider experienced in the diagnosis and management of Rett Syndrome (e.g. neurologist, pediatric neurologist).
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DAYVIGO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with narcolepsy.
Required Medical Information	Insomnia: Member has a diagnosis of insomnia, characterized by difficulties with sleep onset and/or sleep maintenance AND member has had previous treatment, contraindication, or intolerance to Belsomra (suvorexant) or trazodone tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DDAVP - AMPUL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

decitabine - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Myelodysplastic Syndromes. The member has a diagnosis of myelodysplastic syndrome AND one of the following scenarios apply: The member has a Revised International Prognostic Scoring System (IPSS-R) of higher risk disease (i.e. intermediate, high, very high) OR The member has a Revised International Prognostic Scoring System (IPSS-R) of lower risk disease (i.e. very low, low, or intermediate) AND one of the following sets of criteria applies: Clinically relevant thrombocytopenia, neutropenia, or increased marrow blasts OR Member has symptomatic anemia AND No 5q deletion AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND Serum erythropoietin levels less than or equal to 500 mU/mL AND An inadequate response to erythropoietins alone or in combination with Revlimid (lenalidomide) AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND 5q deletion AND An inadequate response or intolerance to Revlimid (lenalidomide) AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy. Myeloproliferative Neoplasms: The member has a diagnosis of myelofibrosis (MF)-accelerated phase or MF-blast phase/acute myeloid leukemia. Acute Myelogenous Leukemia (AML). The member has a diagnosis of AML.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

deferasirox - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Platelet counts less than 50,000/mcL. (Per FDA label, Deferasirox is contraindicated in patients with platelets below 50,000).
Required Medical Information	Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload. Initial Request: The Member must meet ALL of the following criteria: Diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions. AND Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment). Continuation of Therapy Request: The Member must meet ALL of the following criteria: Ferritin level must be consistently above 500mcg/L (deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L.) Chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes. Initial Request: The member must meet ALL of the following criteria: The member has a diagnosis of chronic iron overload with non-transfusion dependent thalassemia (NTDT) syndrome AND The member has liver iron (Fe) concentration of at least 5mg/gm of liver dry weight AND The member has a serum ferritin greater than 300 mcg/L. Continuation of Therapy Request: The Member must meet ALL of the following criteria: Liver iron (Fe) concentration of at least 3 mg/gm of liver dry weight AND Serum ferritin greater than 300 mcg/L.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan Year Duration. Reauthorization: Plan year duration.
Other Criteria	
Part B Prerequisite	0

deferasirox - TABLET, DISPERSIBLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Platelet counts less than 50,000/mcL. (Per FDA label, Deferasirox is contraindicated in patients with platelets below 50,000).
Required Medical Information	Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload. Initial Request: The Member must meet ALL of the following criteria: Diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions. AND Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment). Continuation of Therapy Request: The Member must meet ALL of the following criteria: Ferritin level must be consistently above 500mcg/L (deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L.) Chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: The member must meet ALL of the following criteria: The member has a diagnosis of chronic iron overload with non-transfusion dependent thalassemia (NTDT) syndrome AND The member has liver iron (Fe) concentration of at least 5mg/gm of liver dry weight AND The member has a serum ferritin greater than 300 mcg/L. Continuation of Therapy Request: The Member must meet ALL of the following criteria: Liver iron (Fe) concentration of at least 3 mg/gm of liver dry weight AND Serum ferritin greater than 300 mcg/L.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan Year Duration. Reauthorization: Plan year duration.
Other Criteria	
Part B Prerequisite	0

deferiprone - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members experiencing less than a 20% decline in serum ferritin since initiation of Ferriprox therapy.
Required Medical Information	Transfusional Iron Overload - Thalassemia Syndromes. The member has a diagnosis of transfusional iron overload secondary to Thalassemia and requires transfusion dependence. The member has persistent serum ferritin levels greater than 2,500 mcg/L despite prior treatment with, contraindication, intolerance to deferasirox tablets (generic Jadenu).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

DEFITELIO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Concomitant administration with systemic anticoagulant (e.g. enoxaparin, warfarin, apixaban) or fibrinolytic therapy (e.g. alteplase)
Required Medical Information	Veno-occlusive disease (VOD)/Sinusoidal Obstruction Syndrome (SOS):The member has a diagnosis of veno-occlusive disease (VOD), also known as sinusoidal obstruction syndrome (SOS), following hematopoietic stem-cell transplantation (HSCT) AND The member has renal or pulmonary dysfunction as a result of sinusoidal obstruction syndrome (SOS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	60 Day Duration
Other Criteria	NA
Part B Prerequisite	0

deflazacort - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Duchenne Muscular Dystrophy: The member must have a diagnosis of Duchenne Muscular Dystrophy confirmed by dystrophin genetic testing AND the member has onset of muscle weakness before 5 years of age AND the member has had previous treatment of prednisone for at least 6 months and experienced one of the following: undesirable weight gain defined as more than 20% of body weight gain increase from baseline that required prednisone dose reduction OR a severe behavioral adverse effect (e.g., unmanageable irritation, aggression) that required prednisone dose reduction.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DENAVIR - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Recurrent herpes labialis (cold sores): Member has a diagnosis of recurrent herpes labialis (cold sores) AND the member has had previous treatment, contraindication, or intolerance with oral acyclovir and valacyclovir.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

DEPEN TITRATABS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Wilson's Disease: The member has a diagnosis of Wilson's Disease confirmed by one of the following: presence of Kayser-Fleischer rings and low serum ceruloplasmin (CPN), molecular generic confirmation OR liver biopsy confirmation AND has had previous treatment or intolerance with generic penicillamine tablet. Cystinuria: The member has a diagnosis of cystinuria AND will be using in combination with all the following preventative measures unless there is a contraindication or intolerance to their use: high fluid intake (i.e. at least 2.5 liters daily), elevation of urine pH with potassium citrate and dietary modifications (i.e. limited sodium and protein intake) AND has previously been unresponsive to these preventative measures alone or has a contraindication or intolerance to their use AND has had previous treatment or intolerance with generic penicillamine tablet. Rheumatoid arthritis: The member has a diagnosis of rheumatoid arthritis AND has had previous treatment or intolerance with one of the following conventional treatments: hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine AND has had previous treatment or intolerance with generic penicillamine tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DEPO-TESTOSTERONE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Metastatic Breast Cancer (testosterone enanthate only) OR Delay Puberty in Males (testosterone enanthate only) OR Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

dermacinrx lidocan - ADHESIVE PATCH, MEDICATED

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Herpetic Neuralgia: The member must have a diagnosis of post-herpetic neuralgia. Diabetic Neuropathy: The member must have a diagnosis of diabetic neuropathy. Neuropathic cancer pain. The member has a diagnosis of neuropathic cancer pain. Chronic Back Pain: The member must have a diagnosis of chronic back pain. Pain associated with hip or knee osteoarthritis: the member must have a diagnosis of pain associated with hip or knee osteoarthritis. Brand Lidoderm request only: Members must have previous treatment with generic Lidocaine 5% patch (generic Lidoderm).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DESMODA - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Central diabetes insipidus (neurohypophyseal diabetes insipidus): The member has a diagnosis of central diabetes insipidus (neurohypophyseal diabetes insipidus) AND has had previous treatment or intolerance with generic desmopressin tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

desmopressin - AEROSOL, SPRAY WITH PUMP (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Central diabetes insipidus (neurohypophyseal diabetes insipidus): The member has a diagnosis of central diabetes insipidus (neurohypophyseal diabetes insipidus) AND has had previous treatment or intolerance with generic desmopressin tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DESOXYN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DETROL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DETROL LA - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DEXEDRINE SPANSULE - CAPSULE, EXTENDED RELEASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DEXILANT - CAPSULE, DELAYED RELEASE, BIPHASIC

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DIACOMIT - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of seizures associated with Dravet syndrome AND Diacomit is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member is refractory on current therapy (e.g experiencing generalized tonicclonic or clonic seizures within the past 28 days) AND The member is taking concomitant clobazam therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

dichlorphenamide - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Periodic paralysis: The member must have a diagnosis of primary hyperkalemic or hypokalemic periodic paralysis, or variants of periodic paralysis (i.e. Paramyotonia Congenita, Andersen-Tawil Syndrome) AND The member has had previous treatment, contraindication, or intolerance with acetazolamide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

diclofenac epolamine - PATCH, TRANSDERMAL 12 HOURS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Topical treatment of acute pain due to minor strains, sprains, and contusions.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

diclofenac sodium - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Actinic Keratosis: The member has a diagnosis of actinic keratosis. The member has trial, intolerance, or contraindication to generic imiquimod 5% cream or topical fluorouracil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

diclofenac sodium - SOLUTION IN METERED-DOSE PUMP (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Osteoarthritis. Member has a diagnosis of osteoarthritis of the knee(s).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DIFFERIN - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DIFLUCAN - SUSPENSION, RECONSTITUTED, ORAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

dihydroergotamine - AEROSOL, SPRAY WITH PUMP (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute treatment of moderate to severe migraine headaches with or without aura AND has had previous treatment, intolerance, or contraindication to two of the following: naproxen tablet, naratriptan tablet, rizatriptan tablet, sumatriptan tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DILAUDID - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

dimethyl fumarate - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DIOVAN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DIOVAN HCT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DOJOLVI - LIQUID (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Long-Chain Fatty Acid Oxidation Disorders: The member has a diagnosis of long-chain fatty acid disorders (e.g. Very Long-chain acylCoA Dehydrogenase [VLCAD] deficiency, Carnitine Palmitoyltransferase 2 [CPT2] deficiency, Mitochondrial Trifunctional Protein [TFP] Deficiency, Long-chain 3 hydroxyacylCoA Dehydrogenase [LCHAD] deficiency) AND Genetic and/or molecular testing has been performed to confirm diagnosis (e.g. positive for pathogenic mutations in CPT2, ACADVL, HADHA, or HADHB).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

DOPTELET (10 TAB PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Thrombocytopenia in Chronic Liver Disease (CLD) (Adults) - Doptelet tablet. Member has a diagnosis of chronic liver disease (CLD) AND Member is scheduled to undergo a procedure and would otherwise require a platelet transfusion AND Doptelet will be initiated 10-13 days prior to the procedure, ensuring 5-8 days have elapsed after the last dose before the procedure. Chronic Immune Thrombocytopenia (cITP) (Adults) - Doptelet tablet (Initial): Member has a diagnosis of chronic immune thrombocytopenia AND member has a platelet count of less than 30,000 microliters (applies to most recent result) AND member has had an insufficient response or is intolerant to corticosteroids or member has had a splenectomy with an inadequate response and had an insufficient response or is intolerant to post-splenectomy corticosteroids. Continuation of therapy: member has a platelet count of less than 400 X 10 ⁹ /L. Persistent or Chronic Immune Thrombocytopenia (Pediatrics) (Initial): Has a diagnosis of persistent or chronic immune thrombocytopenic purpura (minimum 3-month disease history) AND Has documented failure, intolerance, or contraindication to at least one course of prednisone or dexamethasone OR Has had a splenectomy. Continuation of therapy: member has a platelet count of less than 400 X 10 ⁹ /L.
Age Restriction	Persistent or Chronic Immune Thrombocytopenia (Pediatrics): Member is 1 year to less than 6 years of age and request is for Doptelet Sprinkle OR Member is 6 years to less than 18 years of age and request is for Doptelet tablet.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	cITP and Persistent or Chronic Immune Thrombocytopenia Initial: 3 months duration. Reauthorization: 6 months duration. CLD: 3 months duration.
Other Criteria	
Part B Prerequisite	0

DOPTELET (15 TAB PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Thrombocytopenia in Chronic Liver Disease (CLD) (Adults) - Doptelet tablet. Member has a diagnosis of chronic liver disease (CLD) AND Member is scheduled to undergo a procedure and would otherwise require a platelet transfusion AND Doptelet will be initiated 10-13 days prior to the procedure, ensuring 5-8 days have elapsed after the last dose before the procedure. Chronic Immune Thrombocytopenia (cITP) (Adults) - Doptelet tablet (Initial): Member has a diagnosis of chronic immune thrombocytopenia AND member has a platelet count of less than 30,000 microliters (applies to most recent result) AND member has had an insufficient response or is intolerant to corticosteroids or member has had a splenectomy with an inadequate response and had an insufficient response or is intolerant to post-splenectomy corticosteroids. Continuation of therapy: member has a platelet count of less than 400 X 10 ⁹ /L. Persistent or Chronic Immune Thrombocytopenia (Pediatrics) (Initial): Has a diagnosis of persistent or chronic immune thrombocytopenic purpura (minimum 3-month disease history) AND Has documented failure, intolerance, or contraindication to at least one course of prednisone or dexamethasone OR Has had a splenectomy. Continuation of therapy: member has a platelet count of less than 400 X 10 ⁹ /L.
Age Restriction	Persistent or Chronic Immune Thrombocytopenia (Pediatrics): Member is 1 year to less than 6 years of age and request is for Doptelet Sprinkle OR Member is 6 years to less than 18 years of age and request is for Doptelet tablet.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	cITP and Persistent or Chronic Immune Thrombocytopenia Initial: 3 months duration. Reauthorization: 6 months duration. CLD: 3 months duration.
Other Criteria	
Part B Prerequisite	0

DOPTELET (30 TAB PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Thrombocytopenia in Chronic Liver Disease (CLD) (Adults) - Doptelet tablet. Member has a diagnosis of chronic liver disease (CLD) AND Member is scheduled to undergo a procedure and would otherwise require a platelet transfusion AND Doptelet will be initiated 10-13 days prior to the procedure, ensuring 5-8 days have elapsed after the last dose before the procedure. Chronic Immune Thrombocytopenia (cITP) (Adults) - Doptelet tablet (Initial): Member has a diagnosis of chronic immune thrombocytopenia AND member has a platelet count of less than 30,000 microliters (applies to most recent result) AND member has had an insufficient response or is intolerant to corticosteroids or member has had a splenectomy with an inadequate response and had an insufficient response or is intolerant to post-splenectomy corticosteroids. Continuation of therapy: member has a platelet count of less than 400 X 10 ⁹ /L. Persistent or Chronic Immune Thrombocytopenia (Pediatrics) (Initial): Has a diagnosis of persistent or chronic immune thrombocytopenic purpura (minimum 3-month disease history) AND Has documented failure, intolerance, or contraindication to at least one course of prednisone or dexamethasone OR Has had a splenectomy. Continuation of therapy: member has a platelet count of less than 400 X 10 ⁹ /L.
Age Restriction	Persistent or Chronic Immune Thrombocytopenia (Pediatrics): Member is 1 year to less than 6 years of age and request is for Doptelet Sprinkle OR Member is 6 years to less than 18 years of age and request is for Doptelet tablet.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	cITP and Persistent or Chronic Immune Thrombocytopenia Initial: 3 months duration. Reauthorization: 6 months duration. CLD: 3 months duration.
Other Criteria	
Part B Prerequisite	0

DOPTELET SPRINKLE - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Thrombocytopenia in Chronic Liver Disease (CLD) (Adults) - Doptelet tablet. Member has a diagnosis of chronic liver disease (CLD) AND Member is scheduled to undergo a procedure and would otherwise require a platelet transfusion AND Doptelet will be initiated 10-13 days prior to the procedure, ensuring 5-8 days have elapsed after the last dose before the procedure. Chronic Immune Thrombocytopenia (cITP) (Adults) - Doptelet tablet (Initial): Member has a diagnosis of chronic immune thrombocytopenia AND member has a platelet count of less than 30,000 microliters (applies to most recent result) AND member has had an insufficient response or is intolerant to corticosteroids or member has had a splenectomy with an inadequate response and had an insufficient response or is intolerant to post-splenectomy corticosteroids. Continuation of therapy: member has a platelet count of less than 400 X 10 ⁹ /L. Persistent or Chronic Immune Thrombocytopenia (Pediatrics) (Initial): Has a diagnosis of persistent or chronic immune thrombocytopenic purpura (minimum 3-month disease history) AND Has documented failure, intolerance, or contraindication to at least one course of prednisone or dexamethasone OR Has had a splenectomy. Continuation of therapy: member has a platelet count of less than 400 X 10 ⁹ /L.
Age Restriction	Persistent or Chronic Immune Thrombocytopenia (Pediatrics): Member is 1 year to less than 6 years of age and request is for Doptelet Sprinkle OR Member is 6 years to less than 18 years of age and request is for Doptelet tablet.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	cITP and Persistent or Chronic Immune Thrombocytopenia Initial: 3 months duration. Reauthorization: 6 months duration. CLD: 3 months duration.
Other Criteria	
Part B Prerequisite	0

doxepin - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of atopic dermatitis or lichen simplex chronicus AND the member has had previous treatment with, contraindication, or intolerance to at least two of the following topical products: triamcinolone, mometasone, fluticasone cream, betamethasone, or clobetasol cream/ointment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DOXIL - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ovarian Cancer: The member has a diagnosis of persistent or recurrent ovarian cancer and one of the following applies: if platinum sensitive, in combination with carboplatin OR if platinum resistant, as a single agent or in combination with bevacizumab product OR The member has a diagnosis ovarian cancer and Liposomal doxorubicin will be used in combination with carboplatin and one of the following applies: perioperative treatment in members who are poor surgical candidates or low likelihood of optimal cytoreduction or adjuvant treatment or primary treatment in members with incomplete previous surgery or staging. Breast Cancer: The member has a diagnosis of recurrent or metastatic HER-2-negative breast cancer. Hodgkin Lymphoma: The member has a diagnosis of relapsed or refractory Hodgkins Lymphoma AND The member will be using liposomal doxorubicin as second-line or subsequent therapy. Kaposi's Sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND One of the following criteria applies: The member has had prior treatment, intolerance, or contraindication to prior systemic chemotherapy, or the member is using Liposomal doxorubicin as first line therapy. Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will be using liposomal doxorubicin in combination with Velcade (bortezomib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration

DOXIL - VIAL (ML)

Other Criteria	Non-Hodgkin's lymphoma: The member has a diagnosis of T-Cell Leukemia or Lymphoma AND Liposomal doxorubicin is given in combination with gemcitabine and vinorelbine and one of the following: for non-responders as first line therapy or for refractory disease after two primary treatment prior to proceeding to transplant OR The member has diagnosis of diffuse large B cell lymphoma AND Liposomal doxorubicin is given in combination with RCDOP (rituximab product, cyclophosphamide, vincristine and prednisone) in members with documented poor ventricular or very frail OR The member has a diagnosis of Mycosis Fungoides (MF)/Sezary Syndrome (SS) and liposomal doxorubicin is given and one of the following: primary treatment OR as combination therapy with gemcitabine and vinorelbine prior to proceeding to transplant OR The member has a diagnosis of relapsed or refractory peripheral T-cell lymphoma (not otherwise specified or enteropathy associated Tcell lymphoma) AND Liposomal doxorubicin is given as subsequent therapy in combination therapy with gemcitabine and vinorelbine prior to proceeding to transplant.
Part B Prerequisite	0

doxorubicin, peg-liposomal - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ovarian Cancer: The member has a diagnosis of persistent or recurrent ovarian cancer and one of the following applies: if platinum sensitive, in combination with carboplatin OR if platinum resistant, as a single agent or in combination with bevacizumab product OR The member has a diagnosis ovarian cancer and Liposomal doxorubicin will be used in combination with carboplatin and one of the following applies: perioperative treatment in members who are poor surgical candidates or low likelihood of optimal cytoreduction or adjuvant treatment or primary treatment in members with incomplete previous surgery or staging. Breast Cancer: The member has a diagnosis of recurrent or metastatic HER-2-negative breast cancer. Hodgkin Lymphoma: The member has a diagnosis of relapsed or refractory Hodgkins Lymphoma AND The member will be using liposomal doxorubicin as second-line or subsequent therapy. Kaposi's Sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND One of the following criteria applies: The member has had prior treatment, intolerance, or contraindication to prior systemic chemotherapy, or the member is using Liposomal doxorubicin as first line therapy. Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will be using liposomal doxorubicin in combination with Velcade (bortezomib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration

doxorubicin, peg-liposomal - VIAL (ML)

Other Criteria	Non-Hodgkin's lymphoma: The member has a diagnosis of T-Cell Leukemia or Lymphoma AND Liposomal doxorubicin is given in combination with gemcitabine and vinorelbine and one of the following: for non-responders as first line therapy or for refractory disease after two primary treatment prior to proceeding to transplant OR The member has diagnosis of diffuse large B cell lymphoma AND Liposomal doxorubicin is given in combination with RCDOP (rituximab product, cyclophosphamide, vincristine and prednisone) in members with documented poor ventricular or very frail OR The member has a diagnosis of Mycosis Fungoides (MF)/Sezary Syndrome (SS) and liposomal doxorubicin is given and one of the following: primary treatment OR as combination therapy with gemcitabine and vinorelbine prior to proceeding to transplant OR The member has a diagnosis of relapsed or refractory peripheral T-cell lymphoma (not otherwise specified or enteropathy associated Tcell lymphoma) AND Liposomal doxorubicin is given as subsequent therapy in combination therapy with gemcitabine and vinorelbine prior to proceeding to transplant.
Part B Prerequisite	0

DRIZALMA SPRINKLE - CAPSULE, DELAYED RELEASE SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Major Depressive Disorder, Generalized Anxiety Disorder, or Diabetic Peripheral Neuropathic Pain: The member has a diagnosis of Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), or Diabetic Peripheral Neuropathic Pain (DPNP). The member has prior therapy, intolerance, or contraindication with venlafaxine (IR or ER) AND duloxetine 20mg, 30mg or 60 mg (generic Cymbalta). Chronic Musculoskeletal Pain, Fibromyalgia: The member has a diagnosis of Chronic Musculoskeletal Pain or Fibromyalgia (FM). The member has prior therapy, intolerance, or contraindication with duloxetine 20mg, 30mg or 60 mg (generic Cymbalta).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

droxidopa - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neurogenic Orthostatic Hypotension: The member has symptomatic, neurogenic orthostatic hypotension (NOH) caused by: Primary autonomic failure- Parkinson's disease (PD), multiple system atrophy or pure autonomic failure OR Dopamine beta-hydroxylase deficiency OR Non-diabetic neuropathy. AND the member must have had previous treatment, intolerance, or contraindication to one of the following agents: fludrocortisone OR midodrine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

DUAKLIR PRESSAIR - AEROSOL POWDER, BREATH ACTIVATED (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema AND the member has had previous treatment, contraindication, or intolerance to Stiolto Respimat AND Spiriva Respimat OR Spiriva Handihaler.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DUAVEE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Treatment of moderate to severe vasomotor symptoms associated with menopause:Diagnosis of moderate to severe vasomotor symptoms associated with menopause AND The member must have had previous treatment, intolerance or contraindication to a SSRI [e.g. citalopram, fluoxetine, paroxetine hydrochloride] or venlafaxine. Prevention of osteoporosis: For the prevention of osteoporosis in a member who is postmenopausal AND the member must have had previous treatment, intolerance, or contraindication to either alendronate or Evista (raloxifene).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DUEXIS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid arthritis or osteoarthritis: The member will be using Duexis for the relief of signs and symptoms for rheumatoid arthritis or osteoarthritis AND the member has had previous treatment with two different combinations of a prescription strength NSAID taken with a histamine H2-receptor antagonist.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DUOBRII - LOTION (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of plaque psoriasis AND has had previous treatment, intolerance or contraindication with tazarotene topical cream* (*- tazarotene topical cream has additional prior authorization requirements).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DUOPA - INTESTINAL PUMP SUSPENSION

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Advanced Parkinson's Disease: The member must have a diagnosis of advanced Parkinson's disease. The member is experiencing persistent motor fluctuations despite optimized carbidopa/levodopa therapy AND the member has tried or cannot use one of the following anti-Parkinson agents: Catechol-D-methyl transferase (COMT) inhibitor (e.g. entacapone) Monoamine oxidase B (MAO)-B inhibitor (e.g. rasagiline, selegiline), Dopamine agonists (e.g. pramipexole, ropinirole), or amantadine. The member must have a gastro-jejunostomy tube (i.e. PEG-J tube) for DUOPA to be delivered directly into the jejunum, using a CADD®-Legacy 1400 portable infusion. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

DUPIXENT PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: The member has a diagnosis of moderate to severe Atopic Dermatitis (e.g. erythema, moderate to severe induration/population, frequent to incessant itching, frequent to nightly loss of sleep) AND The member has had previous treatment, intolerance to, or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/ointment, triamcinolone acetonide 0.5%) OR one topical calcineurin inhibitor (e.g. pimecrolimus cream or tacrolimus). Eosinophilic Esophagitis (EoE): Member must meet all of the following criteria: 15 kg (33 pounds) or higher, Diagnosis of eosinophilic esophagitis (EOE) identified by endoscopic biopsy with evidence of peak cell count of greater than or equal to 15 eosinophils per high power field in 2 or more biopsied esophageal regions, two or more episodes of dysphagia per week, unable to achieve adequate control of symptoms with one guideline directed therapy (e.g., generic high dose proton pump inhibitor OR topical corticosteroid). Chronic Spontaneous Urticaria (CSU): Member has a diagnosis of chronic spontaneous urticaria AND Member has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy, unless contraindicated AND Member will continue to receive H1 antihistamine therapy while on Dupixent, unless contraindicated.
Age Restriction	Atopic dermatitis: The member must be 6 months of age or older. Chronic rhinosinusitis with nasal polyposis and Chronic Spontaneous Urticaria: The member must be 12 years of age or older. Prurigo Nodularis, Bullous Pemphigoid, and COPD with an eosinophilic phenotype: The member must be 18 years of age or older. Eosinophilic Esophagitis: 1 year of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

DUPIXENT PEN - PEN INJECTOR (ML)

Other Criteria	Moderate-to-severe asthma with an eosinophilic phenotypic or with oral corticosteroid dependent asthma: The member has a diagnosis of moderate-to-severe asthma AND The member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of: greater than or equal to 150 cells/uL at therapy initiation, OR greater than or equal to 300 cells/uL in the previous 12 months, OR The member has oral corticosteroid-dependent asthma AND The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy in combination with a long acting beta agonist (eg formoterol). Chronic Rhinosinusitis with Nasal Polyposis: The member must have a diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Dupixent (dupilumab) will be used in conjunction with a daily intranasal corticosteroid spray AND The member has been unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Prurigo Nodularis: member must meet all of the following criteria: diagnosis of Prurigo Nodularis AND prescribed by or in consultation with a dermatologist, allergist, or immunologist. Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype: The member has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) AND The member has an eosinophilic phenotype defined as an elevated peripheral blood eosinophil level of greater than or equal to 300 cells/uL in the previous 12 months AND The member has been unable to achieve adequate control of COPD while on an: Inhaled corticosteroid therapy in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) OR LABA-LAMA therapy if inhaled corticosteroids are contraindicated. Bullous Pemphigoid: The member has a diagnosis of bullous pemphigoid confirmed by biopsy or serologic tests AND Prescribed by or in consultation with a dermatologist, allergist, or immunologist AND member has had previous treatment with, intolerance or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/ointment 0.05%, triamcinolone acetonide 0.5%) OR oral corticosteroid (e.g. prednisone).
Part B Prerequisite	0

DUPIXENT SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: The member has a diagnosis of moderate to severe Atopic Dermatitis (e.g. erythema, moderate to severe induration/population, frequent to incessant itching, frequent to nightly loss of sleep) AND The member has had previous treatment, intolerance to, or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/ointment, triamcinolone acetonide 0.5%) OR one topical calcineurin inhibitor (e.g. pimecrolimus cream or tacrolimus). Eosinophilic Esophagitis (EoE): Member must meet all of the following criteria: 15 kg (33 pounds) or higher, Diagnosis of eosinophilic esophagitis (EOE) identified by endoscopic biopsy with evidence of peak cell count of greater than or equal to 15 eosinophils per high power field in 2 or more biopsied esophageal regions, two or more episodes of dysphagia per week, unable to achieve adequate control of symptoms with one guideline directed therapy (e.g., generic high dose proton pump inhibitor OR topical corticosteroid). Chronic Spontaneous Urticaria (CSU): Member has a diagnosis of chronic spontaneous urticaria AND Member has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy, unless contraindicated AND Member will continue to receive H1 antihistamine therapy while on Dupixent, unless contraindicated.
Age Restriction	Atopic dermatitis: The member must be 6 months of age or older. Chronic rhinosinusitis with nasal polyposis and Chronic Spontaneous Urticaria: The member must be 12 years of age or older. Prurigo Nodularis, Bullous Pemphigoid, and COPD with an eosinophilic phenotype: The member must be 18 years of age or older. Eosinophilic Esophagitis: 1 year of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

DUPIXENT SYRINGE - SYRINGE (ML)

Other Criteria	Moderate-to-severe asthma with an eosinophilic phenotypic or with oral corticosteroid dependent asthma: The member has a diagnosis of moderate-to-severe asthma AND The member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of: greater than or equal to 150 cells/uL at therapy initiation, OR greater than or equal to 300 cells/uL in the previous 12 months, OR The member has oral corticosteroid-dependent asthma AND The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy in combination with a long acting beta agonist (eg formoterol). Chronic Rhinosinusitis with Nasal Polyposis: The member must have a diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Dupixent (dupilumab) will be used in conjunction with a daily intranasal corticosteroid spray AND The member has been unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Prurigo Nodularis: member must meet all of the following criteria: diagnosis of Prurigo Nodularis AND prescribed by or in consultation with a dermatologist, allergist, or immunologist. Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype: The member has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) AND The member has an eosinophilic phenotype defined as an elevated peripheral blood eosinophil level of greater than or equal to 300 cells/uL in the previous 12 months AND The member has been unable to achieve adequate control of COPD while on an: Inhaled corticosteroid therapy in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) OR LABA-LAMA therapy if inhaled corticosteroids are contraindicated. Bullous Pemphigoid: The member has a diagnosis of bullous pemphigoid confirmed by biopsy or serologic tests AND Prescribed by or in consultation with a dermatologist, allergist, or immunologist AND member has had previous treatment with, intolerance or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/ointment 0.05%, triamcinolone acetonide 0.5%) OR oral corticosteroid (e.g. prednisone).
Part B Prerequisite	0

DURYSTA - IMPLANT (EA)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Corneal endothelial cell dystrophy (e.g., Fuchs' Dystrophy). Prior corneal transplantation (e.g., Descemet's Stripping Automated Endothelial Keratoplasty [DSAEK]. Absent or ruptured posterior lens capsule.
Required Medical Information	Open Angle Glaucoma or Ocular Hypertension: The member has been diagnosed with open angle glaucoma or ocular hypertension. AND The treated eye has not received prior treatment with Durysta.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA
Part B Prerequisite	0

DUVYZAT - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Duchenne Muscular Dystrophy (Initial): Member has a diagnosis of Duchenne Muscular Dystrophy (DMD) AND Diagnosis of DMD is confirmed by dystrophin genetic testing AND Duvyzat (givinostat) is prescribed by or in consultation with a specialist (e.g., neurologist) experienced in the management of DMD AND Member is ambulatory (i.e., able to walk independently or with assistance) when Duvyzat (givinostat) therapy is started AND Member is stable on baseline corticosteroids (e.g., prednisone) for at least 6 months before starting therapy with Duvyzat (givinostat) AND Member will continue to take corticosteroids in combination with Duvyzat (givinostat) unless a contraindication exists AND At least one baseline functional test (e.g., North Star Ambulatory Assessment [NSAA], four-stair climb [4SC], six-minute walk test [6MWT], time to walk/run 10 meters [10MWT]) has been performed and documented with results submitted. Duchenne Muscular Dystrophy (Continuation): Member continues to take Duvyzat (givinostat) in combination with corticosteroids, unless a contraindication exists AND Provider attests that member is demonstrating clinical benefit from Duvyzat (givinostat) therapy, based on stabilization of disease or slower than expected decline on functional tests. Documentation of most recent functional test (e.g., North Star Ambulatory Assessment [NSAA], four-stair climb [4SC], six-minute walk test [6MWT], time to walk/run 10 meters [10MWT]) should be submitted.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial and Continuation: Plan year duration
Other Criteria	
Part B Prerequisite	0

EBGLYSS PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: The member has a diagnosis of moderate to severe atopic dermatitis (e.g. erythema that is pink-red to deep or bright red, moderate to severe induration/papulation, frequent or incessant itching, frequent nightly loss of sleep) AND The member must be weigh at least 40 kg AND The member has had previous treatment with, intolerance, or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/ointment, triamcinolone acetonide 0.5%) or one topical calcineurin inhibitor (e.g. tacrolimus ointment) AND The member has had previous treatment with, intolerance, or contraindication to Dupixent.
Age Restriction	The member must be 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

EBGLYSS SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: The member has a diagnosis of moderate to severe atopic dermatitis (e.g. erythema that is pink-red to deep or bright red, moderate to severe induration/papulation, frequent or incessant itching, frequent nightly loss of sleep) AND The member must be weigh at least 40 kg AND The member has had previous treatment with, intolerance, or contraindication to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/ointment, triamcinolone acetonide 0.5%) or one topical calcineurin inhibitor (e.g. tacrolimus ointment) AND The member has had previous treatment with, intolerance, or contraindication to Dupixent.
Age Restriction	The member must be 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

econazole nitrate - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must be using the requested antifungal topically for the treatment of an active susceptible fungal infection AND has had previous treatment, contraindication, or intolerance to two of the following: clotrimazole cream, ciclopirox 0.77% cream/gel/suspension, or ketoconazole cream.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

edaravone - INTRAVENOUS SOLUTION, PIGGYBACK (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): Member has a diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) as determined by a provider who specializes in the treatment of ALS (e.g. neurologist, neuromuscular specialist) AND Member has a baseline score of 2 points or greater for each individual item on the ALS Functional Rating Scale-Revised (ALSFRS-R) AND Member is able to independently perform all or some activities of daily living (ADLs) when therapy is started AND Member has a disease duration of 2 years or less when therapy is started AND Member is also being treated with riluzole OR has previously tried and cannot use riluzole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EFFEXOR XR - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EFFIENT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EFUDEX - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EGRIFTA SV - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	HIV-Associated Lipodystrophy. The member must have a diagnosis of HIV-associated lipodystrophy. The member must utilize Egrifta (tesamorelin) to reduce excess fat for the abdominal area. The member must be/have been on a protease inhibitor (PI) and/or nucleoside reverse transcriptase inhibitor (NRTI).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EGRIFTA WR - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	HIV-Associated Lipodystrophy. The member must have a diagnosis of HIV-associated lipodystrophy. The member must utilize Egrifta (tesamorelin) to reduce excess fat for the abdominal area. The member must be/have been on a protease inhibitor (PI) and/or nucleoside reverse transcriptase inhibitor (NRTI).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EKTERLY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE): The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2 AND The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation. The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND other potential causes of angioedema have been ruled out or considered AND The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist) AND Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH. The member is using Ekterly for the treatment of acute attacks of HAE AND The member has had previous treatment, contraindication, or intolerance to generic icatibant AND Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response, member's specific contraindication to generic icatibant, OR describing the side effects observed with generic icatibant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ELAHERE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Elahere (mirvetuximab soravtansine-gynx).
Required Medical Information	Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer (platinum-resistant disease): The member has a diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer AND The member has platinum-resistant disease AND The member has high levels of folate receptor alpha (FRa) expression (defined as greater than or equal to 75% tumor cells staining with 2+ intensity) AND The member has received at least one to three prior systemic treatment regimens AND The member is using Elahere (mirvetuximab soravtansine-gynx) as single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ELAPRASE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Idursulfase (Elaprase) will require a prior authorization and may be considered medically necessary when the following criteria are met: The patient has a diagnosis of Hunter syndrome Mucopolysaccharidosis II (MPS II).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year
Other Criteria	NA
Part B Prerequisite	0

ELELYSO - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Gaucher Disease. The member has a confirmed diagnosis of Type 1 Gaucher disease.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	NA
Part B Prerequisite	0

ELEVIDYS - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Duchenne Muscular Dystrophy: Member has a diagnosis of Duchenne Muscular Dystrophy (DMD) AND Elevidys (delandistrogene moxeparvovec) is being prescribed by or in consultation with a provider experienced in the diagnosis and treatment of DMD (e.g., neurologist, neuromuscular specialist) AND Member is ambulatory as confirmed by the North Star Ambulatory Assessment (NSAA) (i.e., patient has a score of 1 or greater), and is at least 4 years old. A copy of the most recent NSAA results (within the past 6 months) must be submitted AND Medical records (e.g., chart notes, lab results) must be submitted showing ALL of the following: A mutation in the DMD gene, No deletion in exon 8 or exon 9 in the DMD gene, Baseline liver function tests (e.g., AST, ALT, bilirubin) have been obtained, and Baseline troponin-I levels have been obtained AND Member can take and tolerate corticosteroids (e.g., prednisone) AND Member's anti-AAVrh74 total binding antibody titers are less than 1:400 AND Member does not have evidence of significantly impaired cardiovascular function, as determined by the treating provider AND Member does not have preexisting liver impairment AND Member does not have active hepatic viral infection AND Member has not received a DMD-directed antisense oligonucleotide (i.e., "exon-skipping therapies": casimersen, eteplirsen, golodirsen, viltolarsen) within the past 7 days, and will not receive one of these therapies after administration of Elevidys (delandistrogene moxeparvovec) AND Member has not previously received a dose of Elevidys (delandistrogene moxeparvovec) or any other gene therapy product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months, for a single dose per lifetime
Other Criteria	
Part B Prerequisite	0

ELFABRIO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Fabry Disease: The member has a documented diagnosis of Fabry disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ELIDEL - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Must have a diagnosis of atopic dermatitis and have had previous treatment with one of the following topical generic products: triamcinolone 0.025%, 0.1%, 0.5%, mometasone, betamethasone dipropionate. For Brand Elidel requests must have had previous treatment with pimecrolimus.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ELIGARD - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ELIGARD (3 MONTH) - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ELIGARD (4 MONTH) - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ELIGARD (6 MONTH) - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ELITEK - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members deficient in glucose-6-phosphate dehydrogenase (G6PD).Members who have developed hemolytic reactions or methemoglobinemia related to the use of rasburicase.
Required Medical Information	Hyperuricemia.The member has a diagnosis of leukemia, lymphoma or solid tumor malignancy AND The member is receiving anti-cancer chemotherapy regimen that is expected to cause tumor lysis syndrome (TLS).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ELREXFIO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on a bispecific B-cell maturation antigen (BCMA)- directed CD3 T-cell engager-containing regimen.
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member has relapsed/refractory disease AND The member has received at least four prior lines of therapy, including an anti-CD38 monoclonal antibody (e.g. daratumumab), a proteasome inhibitor (e.g. bortezomib), and an immunomodulatory agent (e.g. lenalidomide) AND The member is using Elrexio (elranatamab-bcmm) as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ELZONRIS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN): The member has a diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) according to World Health Organization (WHO) classification AND the member is able to be an inpatient for at least the first complete course of therapy plus an additional 24 hours for observation.
Age Restriction	The member must be 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

EMEND (FOSAPREPITANT) - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of Chemotherapy-induced nausea and vomiting: Is using for prophylaxis (and not for treatment) of chemotherapy-induced nausea and vomiting AND The member is receiving highly emetogenic chemotherapy (HEC) or moderately emetogenic chemotherapy (MEC) AND One of the following applies: Is taking as part of an antiemetic regimen that includes both a corticosteroid (e.g., dexamethasone) and a 5-HT3 antagonist (ondansetron, dolasetron, palonosetron, or granisetron) OR Has a contraindication to corticosteroids or 5-HT3 antagonists.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EMFLAZA - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Duchenne Muscular Dystrophy: The member must have a diagnosis of Duchenne Muscular Dystrophy confirmed by dystrophin genetic testing AND the member has onset of muscle weakness before 5 years of age AND the member has had previous treatment of prednisone for at least 6 months and experienced one of the following: undesirable weight gain defined as more than 20% of body weight gain increase from baseline that required prednisone dose reduction OR a severe behavioral adverse effect (e.g., unmanageable irritation, aggression) that required prednisone dose reduction.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EMGALITY PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention. Utilizing Emgality (galcanezumab) for the preventative treatment of migraines.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EMGALITY SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Episodic Cluster Headache: The member has been diagnosed with episodic cluster headaches as defined as having at least two cluster periods lasting from 7 days to 1 year, separated by pain free remission periods lasting at least 1 month AND the member has been unable to achieve a reduction in weekly cluster headache attack frequency with a trial of verapamil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EMGALITY SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention. Utilizing Emgality (galcanezumab) for the preventative treatment of migraines.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EMPAVELI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH): The member must meet ALL of the following criteria: Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) defined as: Granulocyte or monocyte clone size of greater than 5% Documentation in the medical record of an LDH level of 1.5 times the upper limit of the normal range. One of the following: Transfusion dependent as defined as ONE of the following: Hemoglobin less than or equal to 7 g/dL or Hemoglobin less than or equal to 9 g/dL and experiencing symptoms of Anemia. Documented history of major adverse vascular events from thromboembolism (e.g., abdominal pain, shortness of breath, chest pain, end organ damage). Continuation of Therapy: The member must meet ALL of the following criteria: Documentation in the medical record demonstrating a positive clinical response from baseline (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions). Complement 3 Glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN): The member has a diagnosis of complement 3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN) confirmed by biopsy AND Empaveli is being used to reduce proteinuria AND The member has tried or cannot use immunosuppressive therapies (e.g., mycophenolate) AND glucocorticoids (e.g., prednisone, dexamethasone, methylprednisolone). BvsD Coverage Determination may also be required.
Age Restriction	C3G or IC-MPGN: The member is 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

EMPLICITI - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members with disease progression while on Empliciti (elotuzumab)
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND One of the following scenarios apply: The member has disease progression after receiving one to three prior lines of therapy AND Empliciti (elotuzumab) will be given in combination with lenalidomide (Revlimid) and dexamethasone OR in combination with bortezomib (Velcade) and dexamethasone OR The member has disease progression after receiving at least two prior therapies, including lenalidomide and a proteasome inhibitor AND Empliciti (elotuzumab) will be given in combination with pomalidomide (Pomalyst) and dexamethasone (Omission of corticosteroid from regimen is allowed if intolerance/contraindication).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA
Part B Prerequisite	0

EMRELIS - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression Emrelis (telisotuzumab vedotin-tllv).
Required Medical Information	Non-small cell lung cancer (NSCLC) [Non-squamous]: The member has a diagnosis of locally advanced or metastatic non-squamous, EGFR wild-type, non-small cell lung cancer (NSCLC) AND The member has high c-Met protein overexpression positive disease, defined as 50% or more of tumor cells with strong (3+) staining (i.e., c-Met/MET greater than or equal to 50% IHC 3+), as determined by an FDA-approved test AND The member has received previous systemic therapy AND Emrelis (telisotuzumab vedotin-tllv) will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

EMROSI - CAPSULE,IMMEDIATE,EXTEND RELEASE,BIPHASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rosacea: Member must be using Emrosi to treat inflammatory lesions of rosacea AND Must have had previous treatment, intolerance, or contraindication with topical metronidazole AND Must have had previous treatment, intolerance, or contraindication with non-delayed release oral doxycycline (e.g. doxycycline monohydrate 50 mg capsule/tablet or 100 mg capsule/tablet or doxycycline hyclate 20 mg tablet or 100 mg capsule/tablet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

EMSAM - PATCH, TRANSDERMAL 24 HOURS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Major Depressive Disorder: The member is an adult with a clinical diagnosis of major depressive disorder (MDD) as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D). The member has had prior therapy, intolerance, or contraindication with a generic SSRI (e.g. citalopram, fluoxetine, paroxetine, or sertraline), generic SNRI (e.g. venlafaxine or duloxetine), a generic bupropion product (75mg/100mg IR, 100mg/150mg/200mg SR, or 150mg/300mg XL) OR mirtazapine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ENBREL - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Juvenile Psoriatic Arthritis: Diagnosis of active juvenile psoriatic arthritis (JPsA). Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide).
Age Restriction	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Juvenile Psoriatic Arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ENBREL MINI - CARTRIDGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Juvenile Psoriatic Arthritis: Diagnosis of active juvenile psoriatic arthritis (JPsA). Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide).
Age Restriction	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Juvenile Psoriatic Arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ENBREL SURECLICK - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Juvenile Psoriatic Arthritis: Diagnosis of active juvenile psoriatic arthritis (JPsA). Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide).
Age Restriction	Must be 18 years of age for Ankylosing Spondylitis, Psoriatic arthritis, or RA. Must be 4 years of age for Plaque Psoriasis. Must be 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Juvenile Psoriatic Arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ENBUMYST - SPRAY, NON-AEROSOL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Edema: Diagnosis of: Congestive heart failure OR Hepatic disease OR Renal disease, including nephrotic syndrome AND Has edema AND Must have previous treatment with a loop diuretic (e.g. furosemide tablets).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ENDARI - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Sickle Cell Disease: The member has a diagnosis of sickle cell disease AND has experienced at least 2 or more sickle cell crises (i.e., medical facility visit for sickle cell related pain, acute chest syndrome, priapism, or hepatic/splenic sequestration) in the previous 12 months AND Has had previous treatment, intolerance, or contraindication with hydroxyurea capsule.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ENHERTU - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Enhertu (fam-trastuzumab deruxtecan-nxki)
Required Medical Information	HER2-Positive Breast cancer: The member has a diagnosis of unresectable or metastatic breast cancer AND The disease is human epidermal growth factor receptor 2 (HER2) positive AND One of the following scenarios applies: Enhertu (fam-trastuzumab deruxtecan- nxki) will be given in combination with a pertuzumab product in the first-line setting OR Enhertu (fam-trastuzumab deruxtecan- nxki) will be given as monotherapy and The member has received prior anti-HER2 based regimens [e.g., trastuzumab-based regimen with or without pertuzumab, Kadcyla (ado-trastuzumab emtansine)]: in the metastatic setting or in the neoadjuvant or adjuvant setting and has developed disease. Gastric or Gastroesophageal Junction Adenocarcinoma: The member has a diagnosis of locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma AND the disease is human epidermal growth factor receptor 2 (HER2) positive AND The member has received prior treatment with prior trastuzumab-based regimen AND Enhertu (fam-trastuzumab deruxtecan-nxki) will be given as monotherapy. HER2-Low Breast cancer: the member has a diagnosis of unresectable or metastatic breast cancer AND the disease is human epidermal growth factor receptor 2 (HER2) low (defined as IHC 1+ or IHC 2+/ISH-negative) AND the member has: received prior chemotherapy regimen(s) in the metastatic setting (e.g. capecitabine, Eribulin, gemcitabine, paclitaxel) OR developed disease recurrence during or within six months of completing adjuvant chemotherapy OR the member has documented hormone receptor (HR)-positive disease and has experienced disease progression on one or more endocrine therapies in the metastatic setting AND Enhertu (fam-trastuzumab deruxtecan-nxki) will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ENHERTU - VIAL (EA)

Other Criteria	HER2-Mutant Non-Small Cell Lung Cancer: the member has a diagnosis of unresectable or metastatic non-small cell lung cancer (NSCLC) AND NSCLC is documented (HER2 (ERBB2)) mutant AND the member has received a prior systemic therapy (e.g. platinum-based therapy, immunotherapy) AND Enhertu (fam-trastuzumab deruxtecan-nxki) will be given as monotherapy. HER2-Positive Solid Tumors: The member has a diagnosis of an unresectable or metastatic solid tumor (e.g., bladder, biliary tract, cervical, colorectal, endometrial, ovarian, salivary gland cancer) AND The disease is human epidermal growth factor receptor 2 (HER2) positive [IHC 3+] AND The member has received prior systemic treatment and has no satisfactory alternative treatment options AND Enhertu (fam-trastuzumab deruxtecan-nxki) will be given as monotherapy. HER2-Ultralow Breast Cancer: The member has a diagnosis of unresectable or metastatic breast cancer AND The disease is human epidermal growth factor receptor 2 (HER2) ultralow (IHC 0+, defined as IHC 0 with faint, partial membrane staining) AND The member has documented hormone receptor (HR)-positive disease and has experienced disease progression on one or more endocrine therapies in the metastatic setting AND Enhertu (fam-trastuzumab deruxtecan-nxki) will be given as monotherapy.
Part B Prerequisite	0

ENJAYMO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cold Agglutinin Disease: Member must meet all of the following criteria: Diagnosis of primary cold agglutinin disease (CAD) as defined by the following: chronic hemolysis (e.g. high reticulocyte count, high LDH, high direct bilirubin, low haptoglobin) AND direct antiglobulin test positive for polyspecific antibodies and strongly positive for C3d AND cold agglutinin titer greater than or equal 64 at 4 degree Celsius. Hemoglobin level less than or equal to 10 g/dL. Total bilirubin level above normal reference range. Vaccinated against encapsulated bacteria at least 2 weeks prior to initiation of Enjaymo therapy according to ACIP recommendations. Not received rituximab within 3 months of initiation or rituximab plus chemotherapy within 6 months of initiation and will not receive concomitant rituximab or rituximab plus chemotherapy with Enjaymo. Does not carry a diagnosis of systemic lupus erythematosus. Continuation of therapy: Member must meet all of the following criteria: Efficacy of Enjaymo (sutimlimab-jome) as defined by one of the following: increase in hemoglobin of 2g/dL or more while on therapy OR normalization of hemoglobin to 12 g/dL or more while on therapy OR decreased need for red blood cell transfusions while on therapy. Not receiving concomitant therapy with rituximab and/or chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ENSACOVE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The member has documented anaplastic lymphoma kinase (ALK)-positive NSCLC disease AND The member has not previously received treatment with an ALK inhibitor and has a medical reason as to why Alecensa (alectinib) or Alunbrig (brigatinib) cannot be initiated or continued as first-line therapy AND Ensacove (ensartinib) will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ENSPRYNG - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neuromyelitis Optica Spectrum Disorder (NMOSD): The member must be anti-aquaporin-4 (AQP4) antibody positive AND The member must have at least ONE of the core clinical characteristics associated with Neuromyelitis Optica Spectrum Disorder (NMOSD) listed below: Optic neuritis, Acute myelitis, Area postrema syndrome: Episode of other unexplained hiccups or nausea and vomiting, Acute brainstem syndrome, Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, Symptomatic cerebral syndrome with NMOSD-typical brain lesions.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ENTRESTO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ENTYVIO - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND the member has had prior therapy, contraindication, or intolerance with Remicade OR Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ENTYVIO PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with intravenous Entyvio. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohns disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with intravenous Entyvio.
Age Restriction	18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ENVARSUS XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Member must have had a kidney transplant AND Must be using Envarsus XR for prophylaxis of organ rejection AND Must be using in combination with other immunosuppressants.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

EOHILIA - SUSPENSION IN PACKET (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Eosinophilic Esophagitis: The member has a diagnosis of eosinophilic esophagitis (EoE) defined as a peak eosinophil cell count of greater than or equal to 15 eosinophils per high power field in 2 or more levels of the esophagus AND The member has experienced at least 4 dysphagia episodes in a two-week period AND Eohilia (budesonide oral suspension) will not be used for more than 12 weeks AND The member has been unable to achieve adequate control of symptoms with at least one of the following: a proton pump inhibitor or a topical corticosteroid AND The member has been unable to achieve adequate control of symptoms with Dupixent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

EPCLUSA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Hepatitis C Virus Genotypes: The member must have a diagnosis of chronic hepatitis C (HCV). For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	
Part B Prerequisite	0

EPIDIOLEX - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dravet Syndrome: The member has a diagnosis of seizures associated with Dravet Syndrome AND Epidiolex (cannabidiol) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has been unable to achieve seizure control with at least one other drug used for the treatment of Dravet Syndrome (e.g. clobazam, valproic acid, topiramate). Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut syndrome AND Epidiolex (cannabidiol) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has been unable to achieve seizure control with at least one other drug used for the treatment of Lennox-Gastaut syndrome (e.g., valproic acid, lamotrigine, topiramate). Tuberous Sclerosis Complex: The member has a diagnosis of seizures associated with Tuberous Sclerosis Complex.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EPIPEN - AUTO-INJECTOR (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EPIPEN 2-PAK - AUTO-INJECTOR (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EPIPEN JR - AUTO-INJECTOR (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EPIPEN JR 2-PAK - AUTO-INJECTOR (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EPKINLY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has active central nervous system (CNS) involvement with lymphoma (DLBCL and High-grade B-cell Lymphoma only). The member experienced disease progression on Epkinly or CD20-directed CD3 T-cell engager.
Required Medical Information	B-cell Non-Hodgkin's Lymphoma. The member has a diagnosis of diffuse large B-cell lymphoma (DLBCL), not otherwise specified (NOS), including DLBCL arising from indolent lymphoma, or high-grade B-cell lymphoma (HGBL) AND The member has received two or more prior lines of systemic therapy AND Epkinly (epcoritamab-bysp) will be used as monotherapy. Follicular Lymphoma: The member has a diagnosis of follicular lymphoma AND One of the following: the member has received two or more lines of systemic therapy AND Epkinly (epcoritamab-bysp) will be used as monotherapy OR Epkinly (epcoritamab-bysp) will be used in combination with lenalidomide and a rituximab product and the member has received at least one line of prior systemic therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

EPOGEN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Anemia of CKD: Diagnosis of anemia associated with chronic kidney disease. Hgb level less than 10.0 g/dL or HCT less than 30- within last 4 weeks. Continue Therapy: Current- within last 4 weeks Hgb level less than 11 g/dL OR documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Anemia in Zidovudine-treated HIV-infected: Diagnosed with HIV (and AZT induced anemia) and receiving zidovudine treatment corresponding with HAART. Endogenous serum erythropoietin levels less than or equal to 500 mUnits/mL. The total zidovudine dose must not exceed 4200mg/wk. Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30-within the last four weeks. Continue Therapy: Zidovudine dose must not exceed 4200mg/wk. Must meet one of the following criteria: Current-within last 4 weeks Hgb level less than 12.0 g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia in Chemotherapy Treated Cancer - first 4 weeks. Diagnosis with a non-myeloid, non-erythroid malignancy. Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than 10.0 g/dL or HCT less than 30-within last 4 weeks. Maint. Phase after first 4 weeks: Member has responded to therapy, defined as one or more of the following: increase in hemoglobin of at least 1 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements OR member has experienced symptom improvement and prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level sufficient to avoid RBC transfusion.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan year duration. Reauth: Plan year duration.

EPOGEN - VIAL (ML)

Other Criteria	Anemia in Surgery Members: Must be scheduled to undergo elective, noncardiac, nonvascular surgery. Must have Hgb level of greater than 10 g/dL and less than or equal 13 g/dL (within last 4 weeks). Anemia in Myelodysplastic Syndromes: symptomatic anemia associated with MDS. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL (unlikely to respond to ESA therapy if erythropoietin level greater than 500mUnits/ml). Must have Hgb level less than 12 g/dL or HCT less than 30 (within last 4 weeks). Cont. Therapy: has responded to therapy, defined as one or more of the following: An increase in hemoglobin of at least 1.5 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements, OR has experienced symptom improvement and prescriber determines to continue therapy. Cont. dosing is needed to maintain the lowest hemoglobin level (not to exceed 12 g/dL) sufficient to avoid RBC transfusion. Anemia associated with Management of Hepatitis C: anemia in management of chronic Hepatitis C. Receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have Hgb level less than or equal to 12.0 gm/dL or HCT less than 30 during combination therapy as defined above(within the last 4 weeks).Continue Therapy: Must be receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV.Must have been able to maintain previous ribavirin dosing without dose reduction due to symptomatic anemia. Must meet one of the following criteria: Current (within the last 4 weeks) Hgb level less than 12.0g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia associated with Rheumatoid Arthritis (RA) Treatment. Diagnosis of anemia associated with pharmaceutical treatment of RA. Receiving active therapy known to cause anemia. Must have Hgb level less than 10 g/dL or HCT less than 30(within the last 4 weeks).Cont. Therapy: Receiving active RA pharmaceutical treatment. Current (within the last 4 weeks) Hgb less than 11 g/dL. For listed indications: Prior to initiation of therapy, other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Prior to initiation of therapy, the members iron scores should be evaluated. Transferrin saturation should be at least 20% OR ferritin at least 100 ng/mL within the last 4 months (applies to most recent result). Cont. of therapy requires documented Transferrin saturation of at least 20% OR ferritin of at least 100 ng/mL within the last 4 months for all indications (applies to most recent result). Must have an inadequate response to Retacrit therapy for at least 2 consecutive months with appropriate dose adjustment.
Part B Prerequisite	0

epoprostenol - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Heart failure caused by reduced left ventricular ejection fraction.
Required Medical Information	Pulmonary Arterial Hypertension (PAH): Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND WHO Functional Class II-IV AND Pulmonary hypertension has progressed despite maximal medical and/or surgical treatment AND Member experiences significant symptoms (e.g. dyspnea on exertion, fatigue, angina, syncope) AND Treatment with oral calcium channel blockers has been tried and failed or has been considered and ruled out. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EPRONTIA - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prophylaxis: Member is using for prophylaxis of migraine headache AND has had previous treatment with or intolerance to immediate release topiramate tablet or capsule AND has had previous treatment, intolerance, or contraindication with one of the following: a serotonin and norepinephrine reuptake inhibitor or a tricyclic antidepressant. Epilepsy Adjunctive Therapy: Member has a diagnosis of partial-onset (focal) seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS) AND Member will use Eprontia (topiramate) in combination with at least one other drug for controlling seizures AND Member has tried or cannot use immediate-release topiramate tablet or capsule. Epilepsy Monotherapy: Member has a diagnosis of partial-onset (focal) seizures or primary generalized tonic-clonic seizures AND Member has tried or cannot use immediate release topiramate tablet or capsule.
Age Restriction	Migraine Prophylaxis: Member must be 12 years of age or older. Epilepsy indications: Member must be 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

EPYSQLI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH): Documentation in the medical record supporting the diagnosis of PNH defined as granulocyte or monocyte clone size of greater than 5% AND Documentation in the medical record of an LDH level of 1.5 times the upper limit of the normal range AND One of the following: Member is transfusion dependent as defined as one of the following: Hemoglobin less than or equal to 7 g/dL OR Both of the following: Hemoglobin less than or equal to 9 g/dL AND Member is experiencing symptoms of anemia OR Member has a documented history of major adverse vascular events from thromboembolism (e.g., abdominal pain, shortness of breath, chest pain, end organ damage). Atypical Hemolytic Uremic Syndrome (aHUS): Documentation supporting the diagnosis of aHUS by ruling out both of the following: Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS) AND Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Generalized Myasthenia Gravis (gMG): the member has a diagnosis of generalized myasthenia gravis AND the presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND the member is being treated by, or under the supervision of, a specialty (e.g. neurologist) experienced in the management of generalized Myasthenia Gravis AND the member has tried or cannot use Vyvgart OR Vyvgart Hytrulo. Neuromyelitis Optica Spectrum Disorder (NMOSD): the member must have at least one of the core clinical characteristics associated with Neuromyelitis Optica Spectrum Disorder (NMOSD) listed below: optic neuritis, acute myelitis, area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions. The member must be anti-aquaporin-4 (AQP4) antibody positive.
Part B Prerequisite	0

EQUETRO - CAPSULE,EXTENDED RELEASE MULTIPHASE 12HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Epilepsy: The member has diagnosis of partial-onset (focal) seizures, generalized tonic-clonic seizures, or mixed seizures AND Member has been unable to achieve seizure control with generic carbamazepine and at least one other drug for controlling seizures (e.g. levetiracetam, topiramate, gabapentin, divalproex, or lamotrigine). Trigeminal neuralgia: The member has a diagnosis of trigeminal neuralgia and member has had previous treatment with a generic carbamazepine formulation. Acute manic or mixed episodes associated with bipolar I disorder: The member has diagnosis of acute manic or mixed episodes associated with bipolar I disorder and member has had previous treatment with a generic carbamazepine formulation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ERBITUX - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with colorectal cancer (CRC) in which RAS mutation status is unknown [Applies to Colorectal Cancer [Wild-Type RAS; Wild-Type KRAS/NRAS]and Colorectal Cancer [KRAS G12C-mutated]. Member has had disease progression on Vectibix or Erbitux. [All Indications]
Required Medical Information	Colorectal Cancer [Wild-Type RAS; Wild-Type KRAS/NRAS]. The member has a diagnosis of advanced or metastatic colorectal cancer (mCRC) AND The member has colorectal cancer that is documented as wild-type, non-mutated KRAS and NRAS [wild-type RAS] AND Erbitux (cetuximab) will be used as one of the following: as monotherapy in members intolerant to irinotecan or who have experienced disease progression following therapy with both irinotecan and oxaliplatin based therapy OR in combination with irinotecan-based therapy OR in combination with fluorouracil based therapy (CAPEOX, FOLFOX, FOLFIRI). Head and Neck Cancer. The member has a diagnosis of locally or regionally advanced squamous cell head and neck cancer with concomitant XRT (radiation) OR The member has recurrent (including locoregional), unresectable, or metastatic squamous cell head and neck cancer and one of the following applies: Erbitux (cetuximab) will be given as monotherapy or Erbitux (cetuximab) will be given in conjunction with a platinum agent OR Erbitux (cetuximab) will be given in combination with platinum-based therapy with 5-FU (fluorouracil). Colorectal Cancer [BRAF V600E-mutated]: The member has documented BRAF V600E metastatic colorectal cancer (mCRC) AND One of the following scenarios applies: The member has documented BRAF V600E metastatic colorectal cancer and progressive disease on prior therapy and Erbitux (cetuximab) will be given in combination with Braftovi (encorafenib) OR The member has documented BRAF V600E metastatic colorectal cancer and Erbitux (cetuximab) will be given in combination with Braftovi (encorafenib) and FOLFOX (fluorouracil, leucovorin, and oxaliplatin) regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ERBITUX - VIAL (ML)

Other Criteria	Colorectal Cancer [KRAS G12C-mutated]. The member has a diagnosis of locally advanced or metastatic colorectal cancer (mCRC) AND The colorectal cancer (CRC) has a documented KRAS G12C mutation, as determined by an FDA-approved test AND The member has received prior systemic treatment with chemotherapy [fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine), oxaliplatin, irinotecan] AND Erbitux (cetuximab) will be given in combination with Krazati (adagrasib).
Part B Prerequisite	0

ERIVEDGE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Erivedge (vismodegib) therapy is not considered medically necessary for members with the following concomitant conditions:Members that have experienced disease progression while on Erivedge (vismodegib). Members that are using Erivedge (vismodegib) as neoadjuvant therapy.
Required Medical Information	Advanced Basal Cell Carcinoma.The member has a diagnosis of metastatic basal cell carcinoma OR The member has a diagnosis of locally advanced basal cell carcinoma AND one of the following applies: The member has disease that has recurred following surgery OR the member is not a candidate for surgery AND radiation.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	NA
Part B Prerequisite	0

ERLEADA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Erleada (apalutamide).
Required Medical Information	Prostate Cancer (non-metastatic castration resistant): The member has a diagnosis of non-metastatic castration resistant prostate cancer AND the member will use Erleada (apalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]). Prostate Cancer (metastatic castration-sensitive): The member has a diagnosis of metastatic castration-sensitive prostate cancer AND the member will use Erleada (apalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or LHRH analog [i.e., LHRH agonist/ antagonist]).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

erlotinib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For brand Tarceva requests: Member must have an intolerance or contraindication to generic erlotinib AND member must meet clinical criteria below. Pancreatic Cancer: The member has a diagnosis of unresectable, locally advanced or metastatic pancreatic cancer. AND erlotinib is being used in combination with gemcitabine. Non-small cell lung cancer. The member has a diagnosis of metastatic NSCLC AND all of the following apply: The member has known documented activated EGFR mutation (such as E19del in exon 19 or L858R in exon 21). Renal Cell Carcinoma: Diagnosis of relapsed or unresectable stage IV renal cell carcinoma with non-clear histology.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

ERMEZA - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member is using for suppression of benign thyroid nodules and nontoxic diffuse goiter in iodine sufficient patients. Member is using for treatment of hypothyroidism during the recovery phase of subacute thyroiditis.
Required Medical Information	Thyroid Supplementation: The member is using levothyroxine as replacement therapy in primary (thyroidal), secondary (pituitary), tertiary (hypothalamic), congenital or acquired hypothyroidism OR The member is using levothyroxine as an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ESBRIET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Idiopathic Pulmonary Fibrosis (IPF):The member meets ALL of the following criteria: Documentation of Pulmonary Fibrosis by one of the following: computed tomography (CT) scan that is indicative of usual interstitial pneumonia (UIP) OR surgical lung biopsy AND Has not had clinically significant environmental exposure or explanation for pulmonary fibrosis or interstitial lung disease (e.g. drugs, asbestos, beryllium, radiation, and domestic birds, radiation, sarcoidosis, hypersensitivity pneumonitis, bronchiolitis, obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, or cancer).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

eslicarbazepine - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND Member will not use Aptiom (eslicarbazepine) in combination with oxcarbazepine AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ESTRACE - CREAM WITH APPLICATOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EUCRISA - OINTMENT (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: The member has a diagnosis of mild to moderate atopic dermatitis (e.g. erythema that is faint pink to pink-red, mild to moderate induration/palpulation) AND the member has at least 5% affected body surface area (BSA) AND the member has had previous treatment, contraindication or intolerance with a topical calcineurin inhibitor (e.g. tacrolimus)* AND The member has had previous treatment, intolerance to, or contraindication to one of the following topical products: triamcinolone, mometasone, betamethasone, or clobetasol cream/ointment. *previous treatment with a calcineurin inhibitor is not required for children less than 2 years of age.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EULEXIN - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of prostate cancer AND will be using Eulexin (flutamide) alone or in combination therapy with a luteinizing hormone-releasing hormone (LHRH) analog.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EURAX - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Scabies. Member must have a diagnosis of scabies AND Has had previous treatment, contraindication or intolerance to permethrin 5% cream AND oral ivermectin. Pruritic Skin. Member must be using to treat pruritis of the skin AND Has had previous treatment, contraindication, or intolerance to a topical corticosteroid (e.g. hydrocortisone, triamcinolone, mometasone) AND an oral antihistamine (e.g. hydroxyzine, levocetirizine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EVENITY - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Evenity (romosozumab-aqqg) is not considered medically necessary for members with the following conditions: Myocardial infarction or stroke within the preceding year. Greater than 12 monthly doses will not be permitted.
Required Medical Information	Osteoporosis in Postmenopausal Women: The member must have a diagnosis of osteoporosis AND the member must be postmenopausal AND The member must meet one of the following criteria: The member must be at a high risk of fracture defined as a history of osteoporotic fracture or multiple risk factors for fracture (e.g. inflammatory joint disorders, diabetes, hyperthyroidism, liver disease) OR The member has failed or is intolerant to other available osteoporosis therapies OR The member must be at VERY HIGH RISK for fracture as defined as: recent fracture (e.g. within the past 12 months) OR fracture while on approved therapy for treatment of osteoporosis OR fracture while on drugs causing skeletal harm (e.g. systemic corticosteroids) OR experienced multiple fractures OR has a very low T-score (e.g. less than -3.0) OR is at high risk for falls or has a history of falls OR has a very high fracture probability per FRAX (e.g. greater than 30% major osteoporotic fracture, greater than 4.5% hip fracture). The member has new fractures or significant loss of bone mineral density despite prior therapy, contraindication or intolerance with at least TWO of the following: Forteo (teriparatide), Prolia (denosumab), and Tymlos (abaloparatide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

everolimus (antineoplastic) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on everolimus.
Required Medical Information	For brand Afinitor requests: Member must have an intolerance or contraindication to generic everolimus AND member must meet clinical criteria below. Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV). Subependymal Giant Cell Astrocytoma (SEGA) with TSC [Adult and Pediatrics]. The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestinal or lung.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Angiomyolipoma and Tuberous Sclerosis Complex (TSC). The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor (HR)positive and human epidermal growth factor receptor 2 (HER2) negative advanced or metastatic disease AND the member has been treated with endocrine therapy (e.g. letrozole, anastrozole) AND The member will use everolimus in combination with exemestane or fulvestrant. Tuberous sclerosis complex (TSC)- associated partial onset seizures [Adults and Pediatrics]: The member has diagnosis of TSC- associated partial onset seizures AND everolimus tablets for oral suspension is being used as adjunctive therapy.
Part B Prerequisite	0

EVISTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EVKEEZA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Homozygous Familial Hypercholesterolemia (HoFH): Member must meet ALL of the following criteria: Diagnosis of Homozygous Familial Hypercholesterolemia defined by ONE of the following: Functional Mutation(s) in both LDL receptor alleles, Presence of Homozygous or compound heterozygous mutations in ApoB or PCSK9 OR untreated LDL-C greater than 400 mg/dL (10.3 mmol/l) with at least one of the following: cutaneous or tendinous xanthoma before the age of 10 years OR Elevated LDL cholesterol levels before lipid-lowering therapy consistent with heterozygous familial hypercholesterolemia in both parents (e.g. untreated LDL-C greater than or equal to 190 mg/dL (4.9 mmol/L)) AND LDL-C is currently greater than 70mg/dL despite treatment on maximally tolerated combination lipid lowering therapy (e.g. statins, ezetimibe, Repatha) AND previous treatment with, contraindication to, or intolerance with Repatha.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EVOCLIN - FOAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EVOXAC - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EVRYSDI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Spinal Muscular Atrophy (SMA): The member has a diagnosis of Spinal Muscular Atrophy documented by SMN1 gene deletion OR 5q SMA homozygous gene deletion, homozygous mutation, or compound heterozygote AND The member has a diagnosis of probable SMA type I, II, or III AND If symptomatic, symptom onset was evident prior to 18 years of age OR If asymptomatic, the member has no more than 4 copies of SMN2 AND The member is being treated by or in consultation with a specialist (e.g. neurologist) experienced in the management of SMA AND The member does not require permanent ventilation at time of administration (defined as requiring a tracheostomy or more than 21 consecutive days of either non-invasive ventilation for 16 hours or more per day or intubation, in the absence of an acute reversible event) AND Baseline functional assessment (e.g. Hammersmith Functional Motor Scale Expanded [HFMSE], Hammersmith Infant Neurological Examination [HINE], Upper Limb Module [ULM], Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND], MFM32), based on age and motor ability, has been completed and submitted AND Genetic testing or lab and chart notes are submitted AND Evrysdi (risdiplam) will NOT be used with other SMN2 directed therapies (e.g. nusinersen).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial and Continuation: Plan year duration
Other Criteria	Reauthorization: The member is responding to therapy, defined by an improvement or maintenance in motor milestones from predicted natural disease progression (e.g. head control, independent sitting, ability to kick in supine position, rolling, crawling) supported by functional assessment evaluation (e.g. Hammersmith Functional Motor Scale Expanded [HFMSE], Hammersmith Infant Neurological Examination [HINE], Upper Limb Module [ULM], Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders [CHOP INTEND], MFM32) AND The member remains free of permanent ventilation (defined as requiring a tracheostomy or more than 21 consecutive days of either non-invasive ventilation for 16 hours or more per day or intubation, in the absence of an acute reversible event).

EVRYSDI - TABLET

Part B Prerequisite	0

EXDENSUR - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Severe Asthma with an Eosinophilic Phenotype: The member has a diagnosis of severe asthma AND the member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of greater than or equal to 150 cells/microliter at therapy initiation OR greater than or equal to 300 cells/microliter in the previous 12 months. The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta agonist (e.g. formoterol). Eosinophilic Granulomatosis with Polyangiitis (EGPA) - Nucala and Fasenra only: The member has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the member has a baseline elevated peripheral blood eosinophil level of greater than 10% of total leukocyte count AND The member has been unable to achieve adequate control of EGPA while on oral corticosteroid therapy (e.g. prednisone, methylprednisolone). Hypereosinophilic Syndrome (HES) - Nucala only: The member has a diagnosis of hypereosinophilic syndrome (HES) for at least 6 months AND The member has a baseline blood eosinophil level of greater than or equal to 1000 cells/microliter.
Age Restriction	Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

EXDENSUR - SYRINGE (ML)

Other Criteria	Chronic Rhinosinusitis with Nasal Polyposis - Nucala Only: The member must meet ALL of the following criteria: Diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Nucala (mepolizumab) will be used in conjunction with a daily intranasal corticosteroid spray AND member is unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) AND Member has an eosinophilic phenotype defined as an elevated peripheral blood eosinophil level of the following before therapy is started: greater than or equal to 150 cells/microliter OR greater than or equal to 300 cells/microliter in the previous 12 months. Member has been unable to achieve adequate control of COPD while on an: Inhaled corticosteroid therapy in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) OR LABA-LAMA therapy if inhaled corticosteroids are contraindicated.
Part B Prerequisite	0

EXELON PATCH - PATCH, TRANSDERMAL 24 HOURS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

exenatide - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using for weight loss.
Required Medical Information	Diabetes Mellitus. The member has a diagnosis of type 2 diabetes mellitus AND Previous treatment with, contraindication to, or intolerance with TWO of the following: Mounjaro, Ozempic, Rybelsus, or Trulicity. Previous treatment requirement does not apply to liraglutide requests for pediatric members (10 to 17 years of age).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EXFORGE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EXFORGE HCT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

EXJADE - TABLET, DISPERSIBLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Platelet counts less than 50,000/mcL. (Per FDA label, Deferasirox is contraindicated in patients with platelets below 50,000).
Required Medical Information	Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload. Initial Request: The Member must meet ALL of the following criteria: Diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions. AND Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment). Continuation of Therapy Request: The Member must meet ALL of the following criteria: Ferritin level must be consistently above 500mcg/L (deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L.) Chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: The member must meet ALL of the following criteria: The member has a diagnosis of chronic iron overload with non-transfusion dependent thalassemia (NTDT) syndrome AND The member has liver iron (Fe) concentration of at least 5mg/gm of liver dry weight AND The member has a serum ferritin greater than 300 mcg/L. Continuation of Therapy Request: The Member must meet ALL of the following criteria: Liver iron (Fe) concentration of at least 3 mg/gm of liver dry weight AND Serum ferritin greater than 300 mcg/L.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan Year Duration. Reauthorization: Plan year duration.
Other Criteria	
Part B Prerequisite	0

EXKIVITY - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Exkivity (mobocertinib).
Required Medical Information	Metastatic Non-Small Cell Lung Cancer (NSCLC): The member has locally advanced or metastatic NSCLC AND The NSCLC has documented EGFR exon 20 insertion mutation AND The member has experienced disease progression on platinum based therapy AND Exkivity (mobocertinib) is administered as single agent as subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

EXSERVAN - FILM, MEDICATED (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): The member has a diagnosis of amyotrophic lateral sclerosis AND the member has previous treatment AND a documented contraindication to riluzole tablets (e.g. impaired ability to swallow tablets).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

EXXUA - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Prolonged QTc interval greater than 450 msec at baseline. Congenital long QT syndrome. Severe hepatic impairment.
Required Medical Information	Major Depressive Disorder: The member must be utilizing Exxua (gepirone) for the treatment of major depressive disorder (MDD) AND The member has had prior therapy, contraindication, or intolerance to any two antidepressants from any of the following categories: generic SSRI (e.g., citalopram, fluoxetine, paroxetine, or sertraline), generic SNRI (e.g., venlafaxine or duloxetine), bupropion OR mirtazapine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FABHALTA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH) - New start: Member has been diagnosed with PNH by, or in collaboration with, a hematologist or PNH specialist AND PNH diagnosis has been confirmed by high sensitivity flow cytometry (granulocyte or monocyte clone greater than 10%) AND Medical record includes a laboratory indicator of hemolysis (i.e., elevated lactate dehydrogenase (LDH), elevated absolute reticulocyte count, elevated total or indirect bilirubin, decreased haptoglobin) AND Member has demonstrated at least two of the following clinical signs of anemia: Average Hemoglobin less than or equal to 10 g/dL over the past six months OR Has received at least one RBC transfusion in the last six months OR Member has symptoms of anemia (e.g., abdominal pain, fatigue, dyspnea). Paroxysmal Nocturnal Hemoglobinuria (PNH) - Stable: Member has been diagnosed with PNH by, or in collaboration with, a hematologist or PNH specialist AND PNH diagnosis has been confirmed by high sensitivity flow cytometry (granulocyte or monocyte clone greater than 10%). Primary Immunoglobulin A Nephropathy (IgAN): Member has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy AND Fabhalta is being used for the reduction of proteinuria in adults at risk of rapid disease progression, e.g., a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g AND One of the following applies to this member: Member has tried and failed a maximally tolerated angiotensin-converting enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB), OR Member has an intolerance or contraindication to all angiotensin-converting enzyme inhibitors (ACEi) or angiotensin II receptor blockers (ARB) AND High risk of CKD progression exists despite optimized supportive care, including both of the following: blood pressure management and lifestyle modification.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration

FABHALTA - CAPSULE

Other Criteria	Complement 3 Glomerulopathy (C3G): The member has a diagnosis of complement 3 glomerulopathy (C3G) confirmed by biopsy AND Fabhalta is being used to reduce proteinuria AND The member has tried or cannot use mycophenolate AND glucocorticoids (e.g., prednisone, dexamethasone, methylprednisolone) AND The member has NOT undergone a kidney transplant.
Part B Prerequisite	0

FABIOR - FOAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Cosmetic indications including solar lentigines, wrinkles, or roughness of the skin in the absence of an approvable indication described in the coverage determination section.
Required Medical Information	Acne Vulgaris. The member must have a diagnosis of acne vulgaris AND The member must have had previous treatment with, intolerance or contraindication to tretinoin (non-micro) or adapalene 0.1% gel.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FABRAZYME - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Fabrazyme (agalsidase beta) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: The member has a documented diagnosis of Fabry disease.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year
Other Criteria	NA
Part B Prerequisite	0

FANAPT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia: The member must be utilizing Fanapt for treatment of schizophrenia. The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (manic or mixed episode): The member must be utilizing Fanapt for the treatment of bipolar I disorder (manic or mixed episode). The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FANAPT TITRATION PACK A - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia: The member must be utilizing Fanapt for treatment of schizophrenia. The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (manic or mixed episode): The member must be utilizing Fanapt for the treatment of bipolar I disorder (manic or mixed episode). The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FANAPT TITRATION PACK B - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia: The member must be utilizing Fanapt for treatment of schizophrenia. The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (manic or mixed episode): The member must be utilizing Fanapt for the treatment of bipolar I disorder (manic or mixed episode). The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FANAPT TITRATION PACK C - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia: The member must be utilizing Fanapt for treatment of schizophrenia. The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (manic or mixed episode): The member must be utilizing Fanapt for the treatment of bipolar I disorder (manic or mixed episode). The member must have prior therapy or intolerance or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FASENRA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Severe Asthma with an Eosinophilic Phenotype: The member has a diagnosis of severe asthma AND the member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of greater than or equal to 150 cells/microliter at therapy initiation OR greater than or equal to 300 cells/microliter in the previous 12 months. The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta agonist (e.g. formoterol). Eosinophilic Granulomatosis with Polyangiitis (EGPA) - Nucala and Fasenra only: The member has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the member has a baseline elevated peripheral blood eosinophil level of greater than 10% of total leukocyte count AND The member has been unable to achieve adequate control of EGPA while on oral corticosteroid therapy (e.g. prednisone, methylprednisolone). Hypereosinophilic Syndrome (HES) - Nucala only: The member has a diagnosis of hypereosinophilic syndrome (HES) for at least 6 months AND The member has a baseline blood eosinophil level of greater than or equal to 1000 cells/microliter.
Age Restriction	Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

FASENRA - SYRINGE (ML)

Other Criteria	Chronic Rhinosinusitis with Nasal Polyposis - Nucala Only: The member must meet ALL of the following criteria: Diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Nucala (mepolizumab) will be used in conjunction with a daily intranasal corticosteroid spray AND member is unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) AND Member has an eosinophilic phenotype defined as an elevated peripheral blood eosinophil level of the following before therapy is started: greater than or equal to 150 cells/microliter OR greater than or equal to 300 cells/microliter in the previous 12 months. Member has been unable to achieve adequate control of COPD while on an: Inhaled corticosteroid therapy in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) OR LABA-LAMA therapy if inhaled corticosteroids are contraindicated.
Part B Prerequisite	0

FASENRA PEN - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Severe Asthma with an Eosinophilic Phenotype: The member has a diagnosis of severe asthma AND the member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of greater than or equal to 150 cells/microliter at therapy initiation OR greater than or equal to 300 cells/microliter in the previous 12 months. The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta agonist (e.g. formoterol). Eosinophilic Granulomatosis with Polyangiitis (EGPA) - Nucala and Fasenra only: The member has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the member has a baseline elevated peripheral blood eosinophil level of greater than 10% of total leukocyte count AND The member has been unable to achieve adequate control of EGPA while on oral corticosteroid therapy (e.g. prednisone, methylprednisolone). Hypereosinophilic Syndrome (HES) - Nucala only: The member has a diagnosis of hypereosinophilic syndrome (HES) for at least 6 months AND The member has a baseline blood eosinophil level of greater than or equal to 1000 cells/microliter.
Age Restriction	Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

FASENRA PEN - AUTO-INJECTOR (ML)

Other Criteria	Chronic Rhinosinusitis with Nasal Polyposis - Nucala Only: The member must meet ALL of the following criteria: Diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Nucala (mepolizumab) will be used in conjunction with a daily intranasal corticosteroid spray AND member is unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) AND Member has an eosinophilic phenotype defined as an elevated peripheral blood eosinophil level of the following before therapy is started: greater than or equal to 150 cells/microliter OR greater than or equal to 300 cells/microliter in the previous 12 months. Member has been unable to achieve adequate control of COPD while on an: Inhaled corticosteroid therapy in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) OR LABA-LAMA therapy if inhaled corticosteroids are contraindicated.
Part B Prerequisite	0

FASLODEX - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Breast Cancer Monotherapy/Single agent therapy. The member has a diagnosis of hormone receptor (HR) positive and human epidermal growth factor receptor 2 (HER2) negative advanced breast cancer and the member has not previously been treated with endocrine therapy (e.g., anastrozole) OR The member has a diagnosis of hormone receptor (HR) positive advanced breast cancer and the member experienced disease progression, intolerance, or has a contraindication to endocrine therapy (e.g., anastrozole) AND The member is post-menopausal or premenopausal but receiving ovarian ablation/suppression AND Fulvestrant is given as monotherapy. Breast Cancer (combination therapy). The member has a diagnosis of hormone receptor (HR) positive and human epidermal growth factor receptor 2 (HER2) negative breast cancer AND The member is post-menopausal or premenopausal but receiving ovarian ablation/suppression and one of the following applies: Fulvestrant will be given in combination with a cyclin-dependent kinase (CDK) 4/6 inhibitor [e.g., abemaciclib, palbociclib, ribociclib] as initial endocrine based therapy for advanced or metastatic disease OR Fulvestrant is given in combination with cyclin-dependent kinase (CDK) 4/6 inhibitor [e.g., abemaciclib, palbociclib, ribociclib] after disease progression on or following endocrine based therapy (e.g., anastrozole) for one of the following: recurrent or unresectable disease OR metastatic disease (Stage IV).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

felbamate - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND The provider attests that the members epilepsy is so severe that the risk of aplastic anemia is deemed acceptable in light of the benefits conferred by its use AND Member has normal baseline serum transaminases (AST/ALT) AND Felbamate (Felbate) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate). Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut syndrome AND Felbamate (Felbate) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The provider attests that the member's epilepsy is so severe that the risk of aplastic anemia is deemed acceptable in light of the benefits conferred by its use AND Member has normal baseline serum transaminases (AST/ALT) AND The member has been unable to achieve seizure control with at least two other drugs used for the treatment of Lennox-Gastaut syndrome (e.g. valproic acid, lamotrigine, rufinamide, topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FELBATOL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FEMARA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FENSOLVI - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Central Precocious Puberty: The member has a diagnosis of central precocious puberty.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FERRIPROX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members experiencing less than a 20% decline in serum ferritin since initiation of Ferriprox therapy.
Required Medical Information	Transfusional Iron Overload - Thalassemia Syndromes. The member has a diagnosis of transfusional iron overload secondary to Thalassemia and requires transfusion dependence. The member has persistent serum ferritin levels greater than 2,500 mcg/L despite prior treatment with, contraindication, intolerance to deferasirox tablets (generic Jadenu).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FERRIPROX (2 TIMES A DAY) - TABLET, MODIFIED RELEASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members experiencing less than a 20% decline in serum ferritin since initiation of Ferriprox therapy.
Required Medical Information	Transfusional Iron Overload - Thalassemia Syndromes. The member has a diagnosis of transfusional iron overload secondary to Thalassemia and requires transfusion dependence. The member has persistent serum ferritin levels greater than 2,500 mcg/L despite prior treatment with, contraindication, intolerance to deferasirox tablets (generic Jadenu).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FETZIMA - CAPSULE, EXTENDED RELEASE 24HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Major depressive disorder: The member must be utilizing Fetzima for treatment of major depressive disorder. For new starts only: The member must have a documentation of prior therapy, intolerance, or contraindication to a serotonin and norepinephrine reuptake inhibitor (SNRI) AND a generic bupropion product (75mg/100mg IR, 100mg/150mg/200mg SR, or 150mg/300mg XL) or mirtazapine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FILSPARI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary immunoglobulin A nephropathy (IgAN). Member has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy AND Filspari is being used to slow kidney function decline in those at risk for disease progression AND One of the following applies to the member: Tried and failed a maximally tolerated angiotensin-converting enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB), or has an intolerance or contraindication to all angiotensin-converting enzyme inhibitors (ACEi) or angiotensin II receptor blockers (ARB) AND Members eGFR is greater than or equal to 30 mL/min/1.73 m ² prior to starting Filspari AND RAS inhibitors (i.e. ACE-I, ARB), endothelin receptor antagonists (i.e. ambrisentan, bosentan, macitentan) and/or aliskiren will be discontinued before starting treatment with Filspari.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FILSUVEZ - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dystrophic and Junctional Epidermolysis Bullosa (DEB and JEB): the member has a diagnosis of dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB) that has been confirmed via genetic testing AND Filsuvez (birch triterpenes) is prescribed by a dermatologist or in consultation with a provider with experience in the management of EB AND the member is concomitantly receiving supportive care for wounds AND documentation (e.g. chart notes, genetic testing results) must be submitted to support the requirements above.
Age Restriction	The member is 6 months of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

fingolimod - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FINTEPLA - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dravet Syndrome: The member has a diagnosis of seizures associated with Dravet Syndrome AND Fintepla (fenfluramine) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has been unable to achieve seizure control with at least one other drug used for the treatment of Dravet Syndrome (e.g. clobazam, valproic acid, topiramate). Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut syndrome AND Fintepla (fenfluramine) is prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist) AND The member has been unable to achieve seizure control with at least two other drugs used for the treatment of Lennox-Gastaut syndrome (e.g. valproic acid, lamotrigine, rufinamide, topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FIRAZYR - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Type 1 and 2: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member is using Firazyr (icatibant) for treatment of acute attacks of HAE. For brand Firazyr requests, the member has had previous treatment or intolerance to generic icatibant. Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response OR describing the side effects observed with generic icatibant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

FIRAZYR - SYRINGE (ML)

Other Criteria	Hereditary Angioedema with normal C1-INH (HAE Type 3): The member must have a diagnosis of hereditary angioedema with normal C1-INH (HAE-nI-C1INH) or type 3. The member must have documented labs showing normal C4 level AND normal C1-INH antigen level AND normal C1-INH functional (%) level. There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered AND The member has episodic angioedema affecting characteristic organs (without urticaria/hives). The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). The member has one of the following: A family history of recurrent angioedema OR Documented labs showing the presence of a mutation associated with HAE-normal-C1INH [i.e. HAE-FXII, HAE-PLG (plasminogen), HAE-ANGPT1 (angiopoietin-1), and HAE-KNG1 (kininogen-1)]. Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. The member is using icatibant for treatment of acute attacks of HAE. For brand Firazyr requests, the member has had previous treatment or intolerance to generic icatibant. Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response OR describing the side effects observed with generic icatibant.
Part B Prerequisite	0

FIRDAPSE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	History of seizures (not to be inferred from pharmacy claims)
Required Medical Information	Lambert-Eaton Myasthenic Syndrome (LEMS). The member has a confirmed diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) by a specialist (e.g. neurologist) AND The diagnosis is supported by results from a clinical evaluation (e.g. electromyography or the presence of autoantibodies directed against VGCC {voltagegated calcium channels}).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FIRMAGON - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FIRMAGON KIT W DILUENT SYRINGE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FLEBOGAMMA DIF - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm³, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

FLEBOGAMMA DIF - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

FLECTOR - PATCH, TRANSDERMAL 12 HOURS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Topical treatment of acute pain due to minor strains, sprains, and contusions.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FOCALIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FOCINVEZ - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of Chemotherapy-induced nausea and vomiting: Is using for prophylaxis (and not for treatment) of chemotherapy-induced nausea and vomiting AND The member is receiving highly emetogenic chemotherapy (HEC) or moderately emetogenic chemotherapy (MEC) AND One of the following applies: Is taking as part of an antiemetic regimen that includes both a corticosteroid (e.g., dexamethasone) and a 5-HT3 antagonist (ondansetron, dolasetron, palonosetron, or granisetron) OR Has a contraindication to corticosteroids or 5-HT3 antagonists.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FOLOTYN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on pralatrexate.
Required Medical Information	Peripheral T-cell Lymphoma(PTCL):relapsed or refractory. Pralatrexate is being used to treat relapsed or refractory peripheral T-cell lymphoma (PTCL) (eg peripheral T-cell lymphoma, not otherwise specified: angioimmunoblastic T-cell lymphoma, anaplastic large cell lymphoma or enteropathy-associated T-cell lymphoma.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FORTEO - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Osteoporosis in Postmenopausal Women: The member must have a diagnosis of osteoporosis AND the member must be postmenopausal AND The member must meet one of the following criteria: The member must be at a high risk of fracture defined as a history of osteoporotic fracture or The member has multiple risk factors for fracture (e.g. inflammatory joint disorders, diabetes, hyperthyroidism, liver disease) OR The member has failed or is intolerant to at least ONE other available osteoporosis therapy (e.g. bisphosphates, RANK-ligand inhibitor, parathyroid hormone analog, sclerostin inhibitor, etc.) OR The member must be at VERY HIGH RISK for fracture as defined as: recent fracture (e.g. within the past 12 months) OR fracture while on approved therapy for treatment of osteoporosis OR fracture while on drugs causing skeletal harm (e.g. systemic corticosteroids) OR experienced multiple fractures OR has a very low T-score (e.g. less than -3.0) OR is at high risk for falls or has a history of falls OR has a very high fracture probability per FRAX (e.g. greater than 30% major osteoporotic fracture, greater than 4.5% hip fracture). Glucocorticoid-Induced Osteoporosis: The member is taking sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone). Hypogonadal Osteoporosis: The member has a diagnosis of primary or hypogonadal osteoporosis AND The member is at high risk of fracture as defined as: a history of osteoporotic fracture OR multiple risk factors for fracture OR The member has new fractures or significant loss of bone mineral density despite previous treatment, contraindication or intolerance with an oral or intravenous bisphosphonate (e.g. alendronate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FORTESTA - GEL IN METERED-DOSE PUMP

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FORZINITY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Barth syndrome: Member has a diagnosis of Barth syndrome AND Provider attests that the diagnosis of Barth syndrome has been genetically confirmed by mutations in the TAFazzin (formerly TAZ) gene AND Member weighs greater than or equal to 30 kg.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FOSAMAX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

fosaprepitant - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of Chemotherapy-induced nausea and vomiting: Is using for prophylaxis (and not for treatment) of chemotherapy-induced nausea and vomiting AND The member is receiving highly emetogenic chemotherapy (HEC) or moderately emetogenic chemotherapy (MEC) AND One of the following applies: Is taking as part of an antiemetic regimen that includes both a corticosteroid (e.g., dexamethasone) and a 5-HT3 antagonist (ondansetron, dolasetron, palonosetron, or granisetron) OR Has a contraindication to corticosteroids or 5-HT3 antagonists.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FOTIVDA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Fotivda (tivozanib).
Required Medical Information	Relapsed or refractory advanced renal cell carcinoma: The member has a diagnosis of relapsed or refractory advanced renal cell carcinoma AND The member has received two prior systemic therapies (e.g., immunoncology checkpoint inhibitors, cabozantinib, axitinib) AND Fotivda (tivozanib) is given as a single agent for subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FRUZAQLA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has had disease progression on Fruzaqla (fruquintinib).
Required Medical Information	Metastatic Colorectal Cancer (mCRC). Member has a diagnosis of metastatic colorectal cancer (mCRC) AND Member has been previously treated with the following: fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy AND anti-VEGF therapy (e.g., bevacizumab product) AND anti-EGFR therapy [if verified KRAS/NRAS wild-type (normal) and medically appropriate].
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FULPHILA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND The member must have a diagnosis of non-myeloid malignancy (e.g. Solid Tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.

FULPHILA - SYRINGE (ML)

Part B Prerequisite	0

fulvestrant - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Breast Cancer Monotherapy/Single agent therapy. The member has a diagnosis of hormone receptor (HR) positive and human epidermal growth factor receptor 2 (HER2) negative advanced breast cancer and the member has not previously been treated with endocrine therapy (e.g., anastrozole) OR The member has a diagnosis of hormone receptor (HR) positive advanced breast cancer and the member experienced disease progression, intolerance, or has a contraindication to endocrine therapy (e.g., anastrozole) AND The member is post-menopausal or premenopausal but receiving ovarian ablation/suppression AND Fulvestrant is given as monotherapy. Breast Cancer (combination therapy). The member has a diagnosis of hormone receptor (HR) positive and human epidermal growth factor receptor 2 (HER2) negative breast cancer AND The member is post-menopausal or premenopausal but receiving ovarian ablation/suppression and one of the following applies: Fulvestrant will be given in combination with a cyclin-dependent kinase (CDK) 4/6 inhibitor [e.g., abemaciclib, palbociclib, ribociclib] as initial endocrine based therapy for advanced or metastatic disease OR Fulvestrant is given in combination with cyclin-dependent kinase (CDK) 4/6 inhibitor [e.g., abemaciclib, palbociclib, ribociclib] after disease progression on or following endocrine based therapy (e.g., anastrozole) for one of the following: recurrent or unresectable disease OR metastatic disease (Stage IV).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FUROSCIX - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Edema: Diagnosis of Heart failure OR Chronic kidney disease, including nephrotic syndrome. Has edema AND must have previous treatment with a loop diuretic (e.g., furosemide tablets).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FUSILEV - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with pernicious anemia or megaloblastic anemia secondary to the lack of vitamin B12.
Required Medical Information	Osteosarcoma: The member is being treated with high dose methotrexate for osteosarcoma. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy OR due to leucovorin calcium formulation necessitating a change in therapy. Impaired methotrexate elimination or inadvertent over dosage of folic acid antagonists. The patient has been treated with methotrexate or other folic acid antagonist and is currently exhibiting signs of toxicity likely due to aforementioned therapy. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy. Advanced Metastatic Colorectal Cancer. The member has advanced metastatic colorectal cancer. The member is receiving palliative treatment with combination chemotherapy with 5-fluorouracil AND The member has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or has experienced documented side effects due to leucovorin calcium formulation necessitating a change in therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

FYARRO - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has a history of severe hypersensitivity to sirolimus, other rapamycin derivatives, or albumin. Member experiences disease progression on Fyarro (sirolimus protein-bound particles for injectable suspension).
Required Medical Information	Perivascular epithelioid cell tumor. The member had diagnosis of locally advanced unresectable or metastatic perivascular epithelioid cell tumor AND Fyarro (sirolimus protein-bound particles for injectable suspension) will be administered as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FYCOMPA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: The member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate). Adjunctive treatment of generalized tonic-clonic seizures: The member has a diagnosis of generalized tonic-clonic seizures AND Member will use Fycompa (perampanel) in combination with at least one other drug for controlling seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling generalized tonic-clonic seizures (e.g. lamotrigine, topiramate, carbamazepine, gabapentin, divalproex).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

FYLNETRA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND The member must have a diagnosis of non-myeloid malignancy (e.g. Solid Tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.

FYLNETRA - SYRINGE (ML)

Part B Prerequisite	0

GALAFOLD - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Fabry Disease. The member has a confirmed diagnosis of Fabry disease AND The member has a galactosidase alpha gene (GLA) variant amenable to migalastat therapy as confirmed by Good Laboratory Practice validated Human Embryonic Kidney (GLP HEK) assay.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

GAMASTAN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GAMASTAN - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

GAMIFANT - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Hemophagocytic Lymphohistiocytosis (HLH). Initial Authorization: Member has documentation in the medical record of a gene mutation known to cause primary HLH (e.g., PRF1, UNC13D) OR Confirmation that at least 5 of the following clinical characteristics are present: Fever greater than or equal to 101.3 degrees F, Splenomegaly, Two of the following cytopenias in the peripheral blood: Hemoglobin less than 9 g/dL or Platelet count less than 100 x 10⁹/L or Neutrophils less than 1 x 10⁹/L, One of the following: Hypertriglyceridemia defined as fasting triglycerides greater than or equal to 3 mmol/L or greater than or equal to 265 mg/dL or Hypofibrinogenemia defined as fibrinogen less than or equal to 1.5 g/L, Hemophagocytosis in bone marrow or spleen or lymph nodes with no evidence of malignancy, Low or absent natural killer cell activity (according to local laboratory reference), Ferritin greater than or equal to 500 mg/L, Soluble CD25 (i.e., soluble IL-2 receptor) greater than or equal to 2,400 U/ml AND Member has refractory, recurrent or progressive disease or intolerance with conventional HLH therapy (i.e., etoposide + dexamethasone) AND Gamifant (emapalumab-lzsg) will be administered with dexamethasone AND Member is a candidate for stem cell transplant AND Gamifant (emapalumab-lzsg) is being used as part of the induction or maintenance phase of stem cell transplant, which is to be discontinued at the initiation of conditioning for stem cell transplant. Reauthorization Criteria: Member is awaiting stem cell transplant and there is documentation in the medical record demonstrating a positive clinical response from baseline.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS): Has confirmed or suspected Still's disease (including systemic Juvenile Idiopathic Arthritis, sJIA or adult onset, AOSD) AND Has a diagnosis of active Hemophagocytic Lymphohistiocytosis (HLH) / Macrophage Activation Syndrome (MAS) AND One of the following applies to the member: Had an inadequate response or intolerance to glucocorticoids OR Has recurrent Macrophage Activation Syndrome (MAS).

GAMIFANT - VIAL (ML)

Part B Prerequisite	0

GAMMAGARD LIQUID - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm³, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GAMMAGARD LIQUID - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

GAMMAGARD LIQUID ERC - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GAMMAGARD LIQUID ERC - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

GAMMAGARD S-D (IGA < 1 MCG/ML) - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GAMMAGARD S-D (IGA < 1 MCG/ML) - VIAL (EA)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

GAMMAKED - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm³, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GAMMAKED - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

GAMMAPLEX - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GAMMAPLEX - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

GAMMAPLEX (WITH SORBITOL) - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GAMMAPLEX (WITH SORBITOL) - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

GAMUNEX-C - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GAMUNEX-C - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

GATTEX 30-VIAL - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Short Bowel Syndrome initial review: Member has a diagnosis of Short Bowel Syndrome. Member is dependent on parenteral support (ie. parenteral nutrition and/or intravenous fluids). Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Reauthorization: Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Need for parenteral support (ie. parenteral nutrition and/or intravenous fluids) has decreased in volume (mL) from baseline weekly requirement at start of Gattex treatment and as documented by actual change in volume. (Note: discontinuation of parental support would be considered a decrease in volume from baseline).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 Months Duration
Other Criteria	
Part B Prerequisite	0

GATTEX ONE-VIAL - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Short Bowel Syndrome initial review: Member has a diagnosis of Short Bowel Syndrome. Member is dependent on parenteral support (ie. parenteral nutrition and/or intravenous fluids). Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Reauthorization: Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Need for parenteral support (ie. parenteral nutrition and/or intravenous fluids) has decreased in volume (mL) from baseline weekly requirement at start of Gattex treatment and as documented by actual change in volume. (Note: discontinuation of parental support would be considered a decrease in volume from baseline).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 Months Duration
Other Criteria	
Part B Prerequisite	0

GAVRETO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on RET inhibitors (e.g., pralsetinib, selpercatinib).
Required Medical Information	Non-small cell lung cancer: The member has a diagnosis of metastatic non-small lung cancer AND the disease is documented as RET fusion positive AND Gavreto (pralsetinib) is being used as monotherapy. Thyroid cancer: The member has a diagnosis of metastatic or advanced thyroid cancer AND The disease is documented RET fusion positive AND The disease is radioactive iodine refractory AND Gavreto (pralsetinib) is being used as monotherapy for systemic therapy.
Age Restriction	Thyroid Cancer: The member is 12 years of age and older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

GAZYVA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	For Follicular Lymphoma and Chronic Lymphocytic Leukemia: Members that have experienced disease progression while on Gazyva (obinutuzumab). For Follicular Lymphoma: The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).
Required Medical Information	Chronic Lymphocytic Leukemia: The member must have a diagnosis of chronic lymphocytic leukemia AND The member is using Gazyva (obinutuzumab) in combination with Chlorambucil OR the member is using Gazyva (obinutuzumab) in combination with bendamustine OR the member is using Gazyva (obinutuzumab) in combination with Venclexta (venetoclax) OR the member is using Gazyva (obinutuzumab) as monotherapy. Follicular Lymphoma: The member has a diagnosis of follicular lymphoma AND One of the following sets of criteria apply: The member will be using Gazyva (obinutuzumab) for first line therapy OR The member has relapsed after, or is refractory to, a rituximab-containing regimen (defined as progression on or within 6 months of prior rituximab product therapy) AND The member will initially be using Gazyva (obinutuzumab) in combination with chemotherapy (e.g. CHOP, CVP, bendamustine) (after 6-8 cycles Gazyva (obinutuzumab) may be continued as monotherapy per reauthorization criteria below). Follicular Lymphoma--Reauthorization Criteria: The member has achieved stable disease, complete response, or partial response after therapy with Gazyva (obinutuzumab) in combination with chemotherapy (e.g, CHOP, CVP, bendamustine). Lupus Nephritis: The member must have a diagnosis of active lupus nephritis AND The member must be utilizing Gazyva in combination with standard therapy (e.g., corticosteroids with mycophenolate or cyclophosphamide).
Age Restriction	Lupus Nephritis: The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

gefitinib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) AND the following applies: The member has a documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation AND The member is using Iressa (gefitinib) as monotherapy (without concomitant chemotherapy).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

GENOTROPIN - CARTRIDGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GENOTROPIN - CARTRIDGE (EA)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

GENOTROPIN MINIQWICK - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

GENOTROPIN MINIQUICK - SYRINGE (EA)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

GEODON - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

GILENYA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

GILOTRIF - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND the following apply: The member has a documented non-resistant epidermal growth factor receptor (EGFR) mutation (sensitizing EGFR mutation e.g., exon 19 deletion, L861Q, S768I, G719X, L858R) AND The member is using Gilotrif (afatinib) as monotherapy (without concomitant chemotherapy) OR squamous cell histology after disease progression on platinum containing chemotherapy and is using Gilotrif (afatinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

GIMOTI - AEROSOL, SPRAY WITH PUMP (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	History of tardive dyskinesia (TD) or a dystonic reaction to metoclopramide.
Required Medical Information	Diabetic Gastroparesis: The member has a diagnosis of diabetic gastroparesis AND has had previous treatment or intolerance with generic metoclopramide (e.g. tablet, solution).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

GIVLAARI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Hepatic Porphyria: Member has a diagnosis of acute hepatic porphyria (acute intermittent porphyria, variegate porphyria, hereditary coproporphyria, or 5'-aminolevulinic acid dehydratase deficiency porphyria) confirmed by elevated porphobilinogen (PBG) and/or aminolevulinic acid (ALA) or genetic confirmation of mutation AND has symptoms consistent with acute hepatic porphyria including a history of symptoms occurring during previous acute attacks or chronically (e.g., pain in the abdomen, back, and/or chest, hypertension, tachycardia, nausea, vomiting, constipation, hyponatremia, neuropathic pain, sensory loss, muscle weakness, paralysis, respiratory failure, confusion, anxiety, depression, memory loss, fatigue, hallucinations, seizures, skin lesions) AND Givlaari (givosiran) will be administered by a healthcare professional.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

GLASSIA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	IgA deficient members or presence of antibodies against IgA.
Required Medical Information	The member must meet ALL of the following criteria: Diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed AND Has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or PI (null, null) or phenotypes associated with reduced serum alpha-1 antitrypsin concentrations, AND an initial serum alpha 1-antitrypsin concentration of less than 57mg/dL when measured by nephelometry OR less than 80 mg/dL when measured by radial immunodiffusion. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema.) For requests for Prolastin-C, Glassia and Aralast-NP: The member must have prior therapy with, intolerance to, or contraindication to Zemaira.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

glatiramer - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

glatopa - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

GLEEVEC - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients that have experienced disease progression while on imatinib.
Required Medical Information	One of the following applies: The member has a diagnosis of Ph+ CML that is newly diagnosed in the chronic phase OR The member has a diagnosis of Ph+ CML that is in accelerated phase or blast crisis OR The member has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha therapy. Acute lymphoid leukemia (ALL). The member has a diagnosis of Ph+ ALL that is relapsed, refractory, or newly diagnosed and imatinib is being added to consolidation or induction therapy OR the member has a diagnosis of PH+ALL and receiving maintenance therapy. The member has a diagnosis of Kit (CD117)-positive GIST. The member has a diagnosis of Dermatofibrosarcoma protuberans (DFSP) that is adjuvant (positive surgical margins following excision) unresectable, recurrent, and/or metastatic. The member has a diagnosis of chronic eosinophilic leukemia or hypereosinophilic syndrome. The member has a diagnosis of MDS or chronic MPD that is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangement.(ex. Chronic myelomonocyte leukemia, atypical chronic myeloid leukemia, juvenile myelomonocyte leukemia).The member has a diagnosis of aggressive systemic mastocytosis. The member must not harbor the D816v mutation of C-kit. Melanoma. The member has a diagnosis of unresectable melanoma with activating mutation of C-kit. Imatinib will be used as single agent in subsequent therapy.
Age Restriction	[Pediatric] Chronic myeloid leukemia (CML) and [Pediatric] Acute Lymphoid Leukemia (ALL)- The member is at least one year of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Pediatric indications: The patient has a diagnosis of Philadelphia chromosome positive (Ph+) CML that is newly diagnosed in chronic phase OR The patient has a diagnosis of Ph+ CML that is in chronic phase with disease recurrence after stem cell transplant OR The patient has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha therapy. Acute Lymphoid Leukemia (ALL). The member is newly diagnosed with Ph+ ALL AND the member will be using imatinib in combination with chemotherapy. Brand Gleevec requests only (all indications): Members must have an intolerance or contraindication with generic imatinib.

GLEEVEC - TABLET

Part B Prerequisite	0

GLEOSTINE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Gleostine (lomustine).
Required Medical Information	Brain Tumors. The member has a diagnosis of primary or metastatic brain tumor AND one of the following applies: the member will use Gleostine (lomustine) after appropriate surgical and/or radiotherapeutic procedures OR the member has recurrent or progressive disease. Hodgkin Lymphoma. The member has a diagnosis of Hodgkin Lymphoma AND the member has disease progression following initial chemotherapy AND the member will use Gleostine (lomustine) as a component of combination chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

GLOPERBA - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of gout flares. The member has a diagnosis of gout AND The member will be using colchicine products for the prophylaxis of gout flares AND The member will be using concomitant or has a contraindication to urate lowering therapy AND The member has had previous treatment failure with colchicine tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

glutamine (sickle cell) - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Sickle Cell Disease: The member has a diagnosis of sickle cell disease AND has experienced at least 2 or more sickle cell crises (i.e., medical facility visit for sickle cell related pain, acute chest syndrome, priapism, or hepatic/splenic sequestration) in the previous 12 months AND Has had previous treatment, intolerance, or contraindication with hydroxyurea capsule.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

GLYCEROL PHENYLBUTYRATE - LIQUID (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Treatment of N-acetylglutamate synthetase (NAGS) deficiency.
Required Medical Information	Urea Cycle Disorders. The member has a diagnosis of urea cycle disorders (UCDs) AND the member will be using Ravicti in combination with a low protein diet AND the member has tried or cannot use a sodium phenylbutyrate product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

GOCOVRI - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Levodopa Induced Dyskinesia in Parkinson's Disease: The member has a diagnosis of dyskinesia associated with Parkinson's Disease AND The member must be receiving levodopa based therapy AND The member has had an inadequate response to immediate release amantadine. Parkinson's disease "off" episodes: The member has a diagnosis of Parkinson's disease AND Is currently taking carbidopa/levodopa and will continue taking carbidopa/levodopa with Gocovri AND Is experiencing "off" episodes AND Has had previous treatment with, or has a contraindication or intolerance to at least two of the following: a dopamine agonist (e.g. pramipexole IR, ropinirole IR), OR a monoamine oxidase-B (MAO-B) inhibitor (e.g. rasagiline, selegiline), OR a catechol-O-methyltransferase (COMT) inhibitor (e.g. entacapone).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

GOMEKLI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neurofibromatosis type 1 (NF1): The member has symptomatic plexiform neurofibromas (PN) [neurofibromatosis type 1 (NF1)] AND The disease is not amenable to complete resection.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

GRANIX - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member had previous treatment or intolerance to both of the the following: Zarxio (filgrastim-sndz) and Nivestym (filgrastim-aafi) AND Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

GRASTEK - TABLET, SUBLINGUAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Allergic Rhinitis with or without Conjunctivitis. Member must have a diagnosis of allergic rhinitis with or without conjunctivitis. Diagnosis has been confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the species contained in the product. Member must have been unable to achieve adequate symptom control with a nasal corticosteroid (e.g. fluticasone) AND a nasal antihistamine (e.g. azelastine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

HADLIMA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HADLIMA - SYRINGE (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HADLIMA PUSHTOUCH - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HADLIMA PUSHTOUCH - AUTO-INJECTOR (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HADLIMA(CF) - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HADLIMA(CF) - SYRINGE (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HADLIMA(CF) PUSHTOUCH - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HADLIMA(CF) PUSHTOUCH - AUTO-INJECTOR (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HAEGARDA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Type 1 and 2 Prophylaxis: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH. The member must be using Haegarda for prophylaxis to prevent attacks of HAE.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HAEGARDA - VIAL (EA)

Other Criteria	Hereditary Angioedema with normal C1-INH (HAE Type 3) Prophylaxis: The member must have a diagnosis of hereditary angioedema with normal C1-INH (HAE-nl-C1INH) or type 3. The member must have documented labs showing normal C4 level AND normal C1-INH antigen level AND normal C1-INH functional (%) level. There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered AND The member has episodic angioedema affecting characteristic organs (without urticaria/hives). The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). The member has one of the following: A family history of recurrent angioedema OR Documented labs showing the presence of a mutation associated with HAE-normal-C1INH [i.e. HAE-FXII, HAE-PLG (plasminogen), HAE-ANGPT1 (angiopoietin-1), and HAE-KNG1 (kininogen-1)]. Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. The member must be using Haegarda for prophylaxis to prevent attacks of HAE.
Part B Prerequisite	0

HALCION - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

HALDOL DECANOATE - AMPUL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

HARLIKU - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Alkaptonuria: Has a diagnosis of alkaptonuria (AKU) AND Diagnosis has been confirmed by one of the following: mutations in the homogentisate 1,2 (HGD) gene detected by molecular genetic testing OR patient has elevated levels of homogentistic acid (HGA) in the urine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

HARVONI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Hepatitis C - Adults: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1,4,5 or 6 infection. HCV RNA level must be documented prior to therapy. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1, 4, 5 or 6 infection. HCV RNA must be documented prior to therapy. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. Chronic Hepatitis C Post Liver Transplant - Member must have received a liver transplant. Member must have experienced recurrent HCV infection post-transplant in the allograft liver. Member must have document genotype 1, 4, 5 or 6 infection. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. Chronic Hepatitis C With Decompensated Cirrhosis - Member must have diagnosis of chronic hepatitis C with decompensated cirrhosis. Member must have genotype 1, 4, 5 or 6 infection. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	8 to 24 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	
Part B Prerequisite	0

HEMADY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multiple myeloma: The member has a diagnosis of multiple myeloma AND The member will use Hemady (dexamethasone) in combination with other antimyeloma therapies (e.g. immunomodulatory, proteasome inhibitors, etc.) AND The member is unable to meet treatment goals with generic dexamethasone tablets or generic dexamethasone intravenous.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

HERCEPTIN - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Herceptin (trastuzumab), Ogivri, Herzuma or Ontruzant requests: member must have an intolerance or contraindication Trazimera (trastuzumab-qyyp) OR Kanjinti (trastuzumab-anns) and meets below criteria: Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive). Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

HERCEPTIN HYLECTA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member is using concomitantly with Kadcyła (ado-trastuzumab emtansine). Member has a diagnosis of gastric or GEJ or esophageal carcinoma.
Required Medical Information	Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease AND Member has intolerance or prior treatment with Trazimera (trastuzumab-qyyp) or Kanjinti (trastuzumab-anns) and one of the following applies: Member is receiving Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) as adjuvant treatment and In combination with paclitaxel or docetaxel following doxorubicin and cyclophosphamide or In combination with docetaxel and carboplatin or Monotherapy following multimodality anthracycline based therapy OR Member is receiving Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) as treatment for metastatic disease and In combination with paclitaxel as first line treatment or monotherapy following one or more combination chemotherapy treatments.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

HERCESSI - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Herceptin (trastuzumab), Ogivri, Herzuma or Ontruzant requests: member must have an intolerance or contraindication Trazimera (trastuzumab-qyyp) OR Kanjinti (trastuzumab-anns) and meets below criteria: Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive). Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

HERNEXEOS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): The member has a diagnosis of unresectable or metastatic, non-squamous, non-small cell lung cancer AND The disease is documented positive for HER2 (ERBB2) tyrosine kinase domain activating mutations AND The member has received prior systemic therapy (e.g., platinum-based chemotherapy) AND Hernexeos (zongertinib) will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

HERZUMA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Herceptin (trastuzumab), Ogivri, Herzuma or Ontruzant requests: member must have an intolerance or contraindication Trazimera (trastuzumab-qyyp) OR Kanjinti (trastuzumab-anns) and meets below criteria: Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive). Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

HETLIOZ - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-24-Hour Sleep-Wake Disorder. The member has a documented diagnosis of Non-24-Hour Sleep-Wake Disorder AND For BRAND HetlioZ or HetlioZ LQ requests the member has had previous treatment or intolerance to generic tasimelteon capsules. Smith-Magenis Syndrome (SMS): The member has a documented diagnosis of SMS AND documented evidence of nighttime sleep disturbances associated with SMS AND For BRAND HetlioZ or HetlioZ LQ requests for ages 16 years and older, the member has had previous treatment or intolerance to generic tasimelteon capsules.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

HETLIOZ LQ - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-24-Hour Sleep-Wake Disorder. The member has a documented diagnosis of Non-24-Hour Sleep-Wake Disorder AND For BRAND Hetloz or Hetloz LQ requests the member has had previous treatment or intolerance to generic tasimelteon capsules. Smith-Magenis Syndrome (SMS): The member has a documented diagnosis of SMS AND documented evidence of nighttime sleep disturbances associated with SMS AND For BRAND Hetloz or Hetloz LQ requests for ages 16 years and older, the member has had previous treatment or intolerance to generic tasimelteon capsules.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

HIPREX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

HIZENTRA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HIZENTRA - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

HORIZANT - TABLET, EXTENDED RELEASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Restless legs syndrome (Moderate to Severe). The member has a diagnosis of moderate to severe Restless legs syndrome. The member have a trial, intolerance, or contraindication to pramipexole AND ropinirole. Postherpetic neuralgia. The member must have a diagnosis of postherpetic neuralgia. The member must have previous treatment, intolerance, or contraindication to gabapentin AND one of the following: pregabalin or Lidocaine 5% topical patch (generic Lidoderm).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

HULIO(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HULIO(CF) - SYRINGE KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HULIO(CF) PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HULIO(CF) PEN - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HUMATROPE - CARTRIDGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMATROPE - CARTRIDGE (EA)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

HUMIRA - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMIRA - SYRINGE KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

HUMIRA PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMIRA PEN - PEN INJECTOR KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

HUMIRA(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMIRA(CF) - SYRINGE KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

HUMIRA(CF) PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMIRA(CF) PEN - PEN INJECTOR KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

HUMIRA(CF) PEN CROHNS-UC-HS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMIRA(CF) PEN CROHNS-UC-HS - PEN INJECTOR KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

HUMIRA(CF) PEN PEDIATRIC UC - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMIRA(CF) PEN PEDIATRIC UC - PEN INJECTOR KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

HUMIRA(CF) PEN PSOR-UV-ADOL HS - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication with all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND The member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance with two of the following: topical corticosteroid therapy (e.g. triamcinolone oral paste), azathioprine, colchicine, cyclosporine.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HUMIRA(CF) PEN PSOR-UV-ADOL HS - PEN INJECTOR KIT (EA)

Other Criteria	Ulcerative colitis: Member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member must have moderately to severely active Crohn's disease. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine).
Part B Prerequisite	0

HYFTOR - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Facial Angiofibroma: the member must meet all of the following criteria: diagnosis of tuberous sclerosis complex (TSC), experiencing greater than or equal to three facial angiofibromas, and is not receiving systemic mTOR inhibitor therapy (e.g. everolimus).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

HYRIMOZ - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HYRIMOZ - SYRINGE (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HYRIMOZ PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HYRIMOZ PEN - PEN INJECTOR (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HYRIMOZ PEN CROHN'S-UC STARTER - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HYRIMOZ PEN CROHN'S-UC STARTER - PEN INJECTOR (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HYRIMOZ PEN PSORIASIS STARTER - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HYRIMOZ PEN PSORIASIS STARTER - PEN INJECTOR (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HYRIMOZ(CF) - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HYRIMOZ(CF) - SYRINGE (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HYRIMOZ(CF) PEDI CROHN STARTER - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HYRIMOZ(CF) PEDI CROHN STARTER - SYRINGE (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HYRIMOZ(CF) PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

HYRIMOZ(CF) PEN - PEN INJECTOR (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

HYRNUO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic non-squamous non-small cell lung cancer (NSCLC) AND The disease is documented positive for HER2 (ERBB2) tyrosine kinase domain (TKD) activating mutations AND The member has received prior systemic therapy (e.g., platinum-based chemotherapy) AND Hyrnuo (sevabertinib) will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

HYZAAR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ibandronate - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Postmenopausal Osteoporosis: The member is a postmenopausal with a diagnosis of osteoporosis or at high risk for osteoporosis. The member has new fractures or significant loss of bone mineral density despite previous treatment contraindication or intolerance to another oral OR intravenous bisphosphonate (e.g. alendronate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year
Other Criteria	
Part B Prerequisite	0

IBRANCE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on CDK 4/6 inhibitor (e.g., ribociclib, abemaciclib).
Required Medical Information	Metastatic Breast Cancer - Combination with Aromatase Inhibitor: The member has a diagnosis of hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND The member will be using Ibrance (palbociclib) in combination with an aromatase inhibitor (e.g., letrozole) as initial endocrine-based therapy for their metastatic or recurrent disease. Metastatic Breast Cancer - Combination with Fulvestrant: The member has a diagnosis of hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND The member will be using Ibrance (palbociclib) in combination with fulvestrant after disease progression on or following endocrine based therapy (e.g. anastrozole) for their recurrent disease or the member will be using Ibrance (palbociclib) in combination with fulvestrant as subsequent therapy after disease progression on or following endocrine based therapy (e.g. anastrozole) for their metastatic disease. Metastatic Breast Cancer - PIK3CA-mutated: The member has a diagnosis of hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND The disease is documented as, PIK3CA-mutated, as detected by an FDA-test AND The member has endocrine resistant disease [i.e., disease progression on or after adjuvant endocrine therapy (e.g., anastrozole, tamoxifen)] AND Ibrance (palbociclib) will be given in combination with Itovebi (inavolisib) and fulvestrant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

IBSRELA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Irritable Bowel Syndrome with Constipation: the member must have a diagnosis of irritable bowel syndrome with constipation AND the member has had previous treatment, intolerance, or contraindication to Linzess (linaclotide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IBTROZI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	ROS1 Positive NSCLC: The member has diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The member has disease which is ROS-1 rearrangement(s) positive AND The member will be using Ibtrozi (taletrectinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ibuprofen-famotidine - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid arthritis or osteoarthritis: The member will be using Duexis for the relief of signs and symptoms for rheumatoid arthritis or osteoarthritis AND the member has had previous treatment with two different combinations of a prescription strength NSAID taken with a histamine H2-receptor antagonist.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

icatibant - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Type 1 and 2: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member is using Firazyr (icatibant) for treatment of acute attacks of HAE. For brand Firazyr requests, the member has had previous treatment or intolerance to generic icatibant. Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response OR describing the side effects observed with generic icatibant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

icatibant - SYRINGE (ML)

Other Criteria	Hereditary Angioedema with normal C1-INH (HAE Type 3): The member must have a diagnosis of hereditary angioedema with normal C1-INH (HAE-nI-C1INH) or type 3. The member must have documented labs showing normal C4 level AND normal C1-INH antigen level AND normal C1-INH functional (%) level. There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered AND The member has episodic angioedema affecting characteristic organs (without urticaria/hives). The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). The member has one of the following: A family history of recurrent angioedema OR Documented labs showing the presence of a mutation associated with HAE-normal-C1INH [i.e. HAE-FXII, HAE-PLG (plasminogen), HAE-ANGPT1 (angiotensinogen-1), and HAE-KNG1 (kininogen-1)]. Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. The member is using icatibant for treatment of acute attacks of HAE. For brand Firazyr requests, the member has had previous treatment or intolerance to generic icatibant. Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response OR describing the side effects observed with generic icatibant.
Part B Prerequisite	0

ICLUSIG - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Iclusig (ponatinib).
Required Medical Information	Chronic Myeloid Leukemia (chronic phase): The member has a diagnosis of chronic phase chronic myeloid leukemia (CML) AND one of the following apply: The member has an intolerance, resistance, or contraindication to at least two available tyrosine kinase inhibitors indicated for the treatment of CML OR The member has a documented T315I mutation. Chronic Myeloid Leukemia (accelerated or blast phase): The member has a diagnosis of accelerated or blast phase chronic myeloid leukemia (CML) AND one of the following apply: There are no other kinase inhibitors indicated OR the member has a documented T315I mutation. Acute Lymphoblastic Leukemia: The member has a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) AND one of the following apply: There are no other kinase inhibitors indicated OR The member has a documented T315I mutation OR Iclusig (ponatinib) will be used in combination with chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ICOTYDE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

IDACIO(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

IDACIO(CF) - SYRINGE KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

IDACIO(CF) PEN - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

IDACIO(CF) PEN - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

IDACIO(CF) PEN CROHN-UC STARTR - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

IDACIO(CF) PEN CROHN-UC STARTR - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

IDACIO(CF) PEN PSORIASIS START - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

IDACIO(CF) PEN PSORIASIS START - PEN INJECTOR KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

IDHIFA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on or following Idhifa(enasidenib).
Required Medical Information	Acute Myeloid Leukemia, Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member has a documented IDH2 mutation AND One of the following applies: The member will be using Idhifa (enasidenib) as monotherapy OR the member will be using Idhifa (enasidenib) as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months). Acute Myeloid Leukemia, Newly diagnosed: The member has a diagnosis of acute myeloid leukemia (AML) AND the member has newly diagnosed disease AND the member is not a candidate for intensive induction therapy due to comorbidities AND the member has a documented IDH2 mutation AND the member will be using Idhifa (enasidenib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	
Part B Prerequisite	0

IGALMI - FILM, MEDICATED (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Agitation Associated with Schizophrenia or Bipolar I or II Disorder: The member has a diagnosis of schizophrenia or bipolar I or II disorder AND The member is experiencing agitation associated with schizophrenia or bipolar I or II disorder.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ILUMYA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Combination therapy with other biologics (e.g. Cosentyx, Enbrel, adalimumab product, Kevzara, Remicade).
Required Medical Information	Moderate to Severe Plaque Psoriasis. The member has a diagnosis of moderate to severe plaque psoriasis AND The member has failed to achieve symptom control (e.g. reduction in erythema, reduction of area of skin involved) after prior therapy with or has intolerance with Remicade OR Inflectra OR infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek).
Age Restriction	Member must be 18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

IMAAVY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Generalized Myasthenia Gravis (gMG): Anti-AChR antibody positive: The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND The member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND The member has tried or cannot use, Vyvgart (efgartigimod alfa-fcab) OR Vyvgart Hytrulo (efgartigimod alfa/hyaluronidase-qvfc). Generalized Myasthenia Gravis (gMG): Anti-MuSK antibody positive: The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-muscle specific tyrosine kinase (MuSK) antibodies has been confirmed AND The member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND The member has tried or cannot use: Pyridostigmine AND At least one immunosuppressive therapy (e.g. azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

imatinib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients that have experienced disease progression while on imatinib.
Required Medical Information	One of the following applies: The member has a diagnosis of Ph+ CML that is newly diagnosed in the chronic phase OR The member has a diagnosis of Ph+ CML that is in accelerated phase or blast crisis OR The member has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha therapy. Acute lymphoid leukemia (ALL). The member has a diagnosis of Ph+ ALL that is relapsed, refractory, or newly diagnosed and imatinib is being added to consolidation or induction therapy OR the member has a diagnosis of PH+ALL and receiving maintenance therapy. The member has a diagnosis of Kit (CD117)-positive GIST. The member has a diagnosis of Dermatofibrosarcoma protuberans (DFSP) that is adjuvant (positive surgical margins following excision) unresectable, recurrent, and/or metastatic. The member has a diagnosis of chronic eosinophilic leukemia or hypereosinophilic syndrome. The member has a diagnosis of MDS or chronic MPD that is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangement.(ex. Chronic myelomonocyte leukemia, atypical chronic myeloid leukemia, juvenile myelomonocyte leukemia).The member has a diagnosis of aggressive systemic mastocytosis. The member must not harbor the D816v mutation of C-kit. Melanoma. The member has a diagnosis of unresectable melanoma with activating mutation of C-kit. Imatinib will be used as single agent in subsequent therapy.
Age Restriction	[Pediatric] Chronic myeloid leukemia (CML) and [Pediatric] Acute Lymphoid Leukemia (ALL)- The member is at least one year of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Pediatric indications: The patient has a diagnosis of Philadelphia chromosome positive (Ph+) CML that is newly diagnosed in chronic phase OR The patient has a diagnosis of Ph+ CML that is in chronic phase with disease recurrence after stem cell transplant OR The patient has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha therapy. Acute Lymphoid Leukemia (ALL). The member is newly diagnosed with Ph+ ALL AND the member will be using imatinib in combination with chemotherapy. Brand Gleevec requests only (all indications): Members must have an intolerance or contraindication with generic imatinib.

imatinib - TABLET

Part B Prerequisite	0

IMBRUVICA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following Imbruvica (ibrutinib).
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). Waldenstroms Macroglobulinemia: The member has a diagnosis of Waldenstroms macroglobulinemia AND The member is using Imbruvica (ibrutinib) as monotherapy or in combination with a rituximab product. Marginal Zone Lymphoma: The member has a diagnosis of marginal zone lymphoma AND The member is using Imbruvica (ibrutinib) as second line or subsequent for refractory or progressive disease AND The member is using Imbruvica (ibrutinib) as monotherapy. Chronic Graft Versus Host Disease: The member has a diagnosis of chronic graft versus host disease (cGVHD) AND The member has been unable to achieve treatment goals with at least one prior line of systemic therapy (e.g. corticosteroids).
Age Restriction	cGVHD: Member age is 1 year or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

IMDELLTRA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on Imdelltra (tarlatamab-dlle).
Required Medical Information	Small Cell Lung Cancer (SCLC): The member has a diagnosis of extensive-stage small cell lung cancer (ES-SCLC) AND the member had progression on or after treatment with platinum-based chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IMFINZI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	All indications except Bladder Cancer and GE/GEJC: Disease progression while on or following anti-PD-1/PD-L1 therapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Tecentriq (atezolizumab), Imfinzi (durvalumab)]. For unresectable stage III NSCLC, member has not exceeded a maximum of twelve (12) months of therapy. For perioperative NSCLC, for adjuvant treatment, and GE/GEJC member has not exceeded a maximum of 12 cycles after surgery.
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC) (unresectable): Member has diagnosis of unresectable stage III non-small cell lung cancer (NSCLC) AND Imfinzi (durvalumab) will be used as consolidation therapy after completion of concurrent platinum containing chemotherapy and radiation AND Member has not experienced progression of disease after at least two cycles of chemotherapy and radiation AND Imfinzi (durvalumab) will be used as monotherapy OR Member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND Member has no documented EGFR or ALK genomic tumor aberrations AND Member will be using Imfinzi in combination with Imjudo and platinum-based chemotherapy as first-line therapy only. Small Cell Lung Cancer: The member has a diagnosis of extensive-stage small cell lung cancer AND Imfinzi will be given in combination with etoposide and carboplatin as first line therapy followed by maintenance therapy with Imfinzi as a single agent. Biliary Tract Cancer: the member has a diagnosis of locally advanced or metastatic biliary tract cancer AND the member will be using Imfinzi (durvalumab) in combination with gemcitabine and cisplatin. Hepatocellular Carcinoma: The member has a diagnosis of locally advanced unresectable and/or metastatic hepatocellular carcinoma AND The member will be using Imfinzi in combination with Imjudo as first-line therapy only. Endometrial cancer: The member has a diagnosis of primary advanced or recurrent endometrial cancer AND the disease is mismatch repair deficient (dMMR) AND Imfinzi (durvalumab) will be used in combination with carboplatin and paclitaxel followed by Imfinzi (durvalumab) as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	6 months Duration.

IMFINZI - VIAL (ML)

Other Criteria	Non-small cell lung cancer (perioperative): The member has a diagnosis of non-small cell lung cancer AND The disease is resectable (tumors greater than 4 cm and/or node positive) AND The disease does not have known epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) rearrangements AND Imfinzi (durvalumab) will be used in combination with chemotherapy as neoadjuvant treatment followed by Imfinzi (durvalumab) as monotherapy as adjuvant treatment after surgery. Small Cell Lung Cancer (Limited stage): The member has a diagnosis of limited-stage small cell lung cancer AND The member's disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy AND Imfinzi (durvalumab) will be given as monotherapy. Bladder Cancer: The member has a diagnosis of muscle invasive bladder cancer (MIBC) AND The member will be using Imfinzi (durvalumab) in combination with gemcitabine and cisplatin as neoadjuvant treatment, followed by a single agent Imfinzi (durvalumab) as adjuvant treatment following radical cystectomy. Gastric or gastroesophageal junction adenocarcinoma (GE/GEJC): The member has a diagnosis of resectable gastric or gastroesophageal junction adenocarcinoma AND Imfinzi (durvalumab) will be used in combination with fluorouracil, leucovorin, oxaliplatin and docetaxel (FLOT) as neoadjuvant and adjuvant treatment, followed by Imfinzi (durvalumab) monotherapy as part of remaining adjuvant treatment.
Part B Prerequisite	0

IMITREX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

IMITREX STATDOSE PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

IMITREX STATDOSE REFILL - CARTRIDGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

IMJUDO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression on Imjudo (tremelimumab-actl)
Required Medical Information	Hepatocellular carcinoma (HCC): The member has diagnosis of unresectable hepatocellular carcinoma AND The member will be given Imjudo (tremelimumab-actl) in combination with Imfinzi (durvalumab). Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic, advanced, recurrent non-small cell lung cancer AND NSCLC does not express sensitizing genomic tumor aberrations (e.g., EGFR, ALK) AND The member will be given Imjudo (tremelimumab-actl) in combination with Imfinzi (durvalumab) and platinum based chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

IMKELDI - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients that have experienced disease progression while on imatinib.
Required Medical Information	One of the following applies: The member has a diagnosis of Ph+ CML that is newly diagnosed in the chronic phase OR The member has a diagnosis of Ph+ CML that is in accelerated phase or blast crisis OR The member has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha therapy. Acute lymphoid leukemia (ALL). The member has a diagnosis of Ph+ ALL that is relapsed, refractory, or newly diagnosed and imatinib is being added to consolidation or induction therapy OR the member has a diagnosis of PH+ALL and receiving maintenance therapy. The member has a diagnosis of Kit (CD117)-positive GIST. The member has a diagnosis of Dermatofibrosarcoma protuberans (DFSP) that is adjuvant (positive surgical margins following excision) unresectable, recurrent, and/or metastatic. The member has a diagnosis of chronic eosinophilic leukemia or hypereosinophilic syndrome. The member has a diagnosis of MDS or chronic MPD that is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangement.(ex. Chronic myelomonocyte leukemia, atypical chronic myeloid leukemia, juvenile myelomonocyte leukemia).The member has a diagnosis of aggressive systemic mastocytosis. The member must not harbor the D816v mutation of C-kit. Melanoma. The member has a diagnosis of unresectable melanoma with activating mutation of C-kit. Imatinib will be used as single agent in subsequent therapy.
Age Restriction	[Pediatric] Chronic myeloid leukemia (CML) and [Pediatric] Acute Lymphoid Leukemia (ALL) - The member is at least one year of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Pediatric indications: The patient has a diagnosis of Philadelphia chromosome positive (Ph+) CML that is newly diagnosed in chronic phase OR The patient has a diagnosis of Ph+ CML that is in chronic phase with disease recurrence after stem cell transplant OR The patient has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha therapy.Acute Lymphoid Leukemia (ALL). The member is diagnosed with Ph+ ALL AND the member will be using imatinib in combination with chemotherapy. For Imkeldi requests (all indications): Members must have an intolerance or contraindication with generic imatinib.

IMKELDI - SOLUTION, ORAL

Part B Prerequisite	0

IMLYGIC - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Members who are immunocompromised. Members who are pregnant. Members that have experienced disease progression while on Imlygic (talimogene laherparepvec). Concomitant therapy with anti-PD-1/PD-L1 agents (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab], Bavencio [avelumab]).
Required Medical Information	Unresectable Melanoma: The member must have one of the following melanoma diagnoses: unresectable Stage III with in-transit metastases, unresectable local/satellite recurrence (may also have in-transit metastases), unresectable or distant metastatic disease. The member will receive Imlygic as an intralesional therapy into cutaneous, subcutaneous, or nodal lesions that are visible on the skin, palpable, or detectable by ultrasound guidance.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA
Part B Prerequisite	0

IMULDOSA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IMULDOSA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohns disease AND the member has had prior therapy, contraindication, or intolerance with Remicade OR Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IMVEXXY MAINTENANCE PACK - INSERT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Dyspareunia: The member must be post-menopausal AND have vulvar and/or vaginal atrophy AND diagnosis of moderate to severe dyspareunia AND has had a previous treatment, intolerance, or contraindication to estradiol vaginal cream or Premarin vaginal cream.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IMVEXXY STARTER PACK - INSERT, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Dyspareunia: The member must be post-menopausal AND have vulvar and/or vaginal atrophy AND diagnosis of moderate to severe dyspareunia AND has had a previous treatment, intolerance, or contraindication to estradiol vaginal cream or Premarin vaginal cream.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INBRIJA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease off episodes: The member has a diagnosis of Parkinson's disease AND is currently taking carbidopa/levodopa and will continue taking carbidopa/levodopa with Inbrija (inhaled levodopa) AND is experiencing breakthrough off periods related to their Parkinson's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INCRELEX - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The bone epiphyses are closed.
Required Medical Information	Member has a diagnosis of GH gene deletion with development of neutralizing antibodies to GH OR The patient has a diagnosis of severe primary IGF-1 deficiency defined by:height standard deviation score below or equal -3.0 and basal IGF-1 standard deviation score below or equal -3.0 and normal or elevated growth hormone.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INCRUSE ELLIPTA - BLISTER, WITH INHALATION DEVICE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema. The member has had previous treatment, contraindication, or intolerance to Spiriva (i.e. Spiriva Handihaler, Spiriva Respimat). For Yupelri requests: BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INDERAL LA - CAPSULE, EXTENDED RELEASE 24HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INFLECTRA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Combination therapy with other biologics (e.g. Cosentyx, Enbrel, adalimumab product, Kevzara, Remicade).
Required Medical Information	Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs and must be on concomitant treatment with methotrexate during therapy, unless contraindicated or intolerant to methotrexate. Crohn's Disease (Non-Fistulizing) and Ulcerative Colitis: Diagnosis of moderate to severely active Crohn's disease OR moderately to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance with a corticosteroid (e.g. prednisone, hydrocortisone, methylprednisolone) OR 5-aminosalicylic acids (e.g. mesalamine, osalazine) OR immunomodulator (e.g. azathioprine or 6-mercaptopurine). Ankylosing Spondylitis: Diagnosis of highly persistent, active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with at least one non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen).
Age Restriction	Must be 18 years of age for Plaque Psoriasis, Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Fistulizing Crohn's Disease. Must be 6 years of age for Crohn's Disease (Non-Fistulizing) and Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

INFLECTRA - VIAL (EA)

Other Criteria	Psoriatic arthritis: Diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. sulfasalazine, methotrexate, leflunomide) or contraindication to all DMARDs. Plaque Psoriasis: Diagnosis of moderate to severe, extensive chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine) or contraindication to all conventional oral systemic treatments. Fistulizing Crohn's Disease: The member must have a diagnosis of Crohn's disease with one or more draining fistulas AND The member has had prior therapy, contraindication, or intolerance with one or more immunosuppressive agents (e.g. azathioprine, 6 mercaptopurine)
Part B Prerequisite	0

INFLIXIMAB - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Combination therapy with other biologics (e.g. Cosentyx, Enbrel, adalimumab product, Kevzara, Remicade).
Required Medical Information	Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs and must be on concomitant treatment with methotrexate during therapy, unless contraindicated or intolerant to methotrexate. Crohn's Disease (Non-Fistulizing) and Ulcerative Colitis: Diagnosis of moderate to severely active Crohn's disease OR moderately to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance with a corticosteroid (e.g. prednisone, hydrocortisone, methylprednisolone) OR 5-aminosalicylic acids (e.g. mesalamine, osalazine) OR immunomodulator (e.g. azathioprine or 6-mercaptopurine). Ankylosing Spondylitis: Diagnosis of highly persistent, active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with at least one non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen).
Age Restriction	Must be 18 years of age for Plaque Psoriasis, Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Fistulizing Crohn's Disease. Must be 6 years of age for Crohn's Disease (Non-Fistulizing) and Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

INFLIXIMAB - VIAL (EA)

Other Criteria	Psoriatic arthritis: Diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. sulfasalazine, methotrexate, leflunomide) or contraindication to all DMARDs. Plaque Psoriasis: Diagnosis of moderate to severe, extensive chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine) or contraindication to all conventional oral systemic treatments. Fistulizing Crohn's Disease: The member must have a diagnosis of Crohn's disease with one or more draining fistulas AND The member has had prior therapy, contraindication, or intolerance with one or more immunosuppressive agents (e.g. azathioprine, 6 mercaptopurine)
Part B Prerequisite	0

INGREZZA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Tardive Dyskinesia. The member is utilizing Ingrezza (valbenazine) for the treatment tardive dyskinesia that is associated with the use of dopamine receptor blocking agents AND Symptoms persist despite one of the following: Discontinuation or reduction in dose of dopamine blocking agent(s) or Discontinuation or reduction in dose of dopamine blocking agent(s) is not possible. OR the member will be using Ingrezza for the treatment of moderate to severe tardive dyskinesia that is not associated with other medication therapies (e.g. dopamine blocking agents). AND the member has had previous treatment, contraindication, or intolerance to Austedo or Austedo XR (deutetrabenazine). Chorea associated with Huntingtons disease: The member has a diagnosis of chorea associated with Huntingtons disease AND the member has had previous treatment, contraindication, or intolerance to Austedo or Austedo XR (deutetrabenazine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INGREZZA INITIATION PK(TARDIV) - CAPSULE, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Tardive Dyskinesia. The member is utilizing Ingrezza (valbenazine) for the treatment tardive dyskinesia that is associated with the use of dopamine receptor blocking agents AND Symptoms persist despite one of the following: Discontinuation or reduction in dose of dopamine blocking agent(s) or Discontinuation or reduction in dose of dopamine blocking agent(s) is not possible. OR the member will be using Ingrezza for the treatment of moderate to severe tardive dyskinesia that is not associated with other medication therapies (e.g. dopamine blocking agents). AND the member has had previous treatment, contraindication, or intolerance to Austedo or Austedo XR (deutetrabenazine). Chorea associated with Huntingtons disease: The member has a diagnosis of chorea associated with Huntingtons disease AND the member has had previous treatment, contraindication, or intolerance to Austedo or Austedo XR (deutetrabenazine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INGREZZA SPRINKLE - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Tardive Dyskinesia. The member is utilizing Ingrezza (valbenazine) for the treatment tardive dyskinesia that is associated with the use of dopamine receptor blocking agents AND Symptoms persist despite one of the following: Discontinuation or reduction in dose of dopamine blocking agent(s) or Discontinuation or reduction in dose of dopamine blocking agent(s) is not possible. OR the member will be using Ingrezza for the treatment of moderate to severe tardive dyskinesia that is not associated with other medication therapies (e.g. dopamine blocking agents). AND the member has had previous treatment, contraindication, or intolerance to Austedo or Austedo XR (deutetrabenazine). Chorea associated with Huntingtons disease: The member has a diagnosis of chorea associated with Huntingtons disease AND the member has had previous treatment, contraindication, or intolerance to Austedo or Austedo XR (deutetrabenazine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INLEXZO - IMPLANT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has perforation of the bladder.
Required Medical Information	Non-muscle invasive bladder cancer (NMIBC): Member has a diagnosis of non-muscle invasive bladder cancer (NMIBC) with documented carcinoma in situ (CIS) with or without papillary tumors AND Member has documented high-risk, Bacillus Calmette-Guérin (BCG)-unresponsive disease, which is defined as persistent or recurrent disease following adequate BCG therapy. Adequate BCG is defined as the administration of at least five of six doses of an initial induction course plus either of: ?at least two of three doses of maintenance therapy OR at least two of six doses of a second induction course. Member is ineligible for or has elected not to undergo cystectomy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INLURIYO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Estrogen Receptor (ER) Positive Breast Cancer: The member has a diagnosis of ER-positive, HER2-negative advanced or metastatic breast cancer AND The breast cancer has a documented ESR1-mutation AND The member has experienced progressive disease following at least one prior line of endocrine therapy (e.g., aromatase inhibitor, CDK 4/6 inhibitor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INLYTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Inlyta (axitinib).
Required Medical Information	Renal Cell Carcinoma: The member has a diagnosis of advanced renal cell carcinoma AND Inlyta will be given as one of the following: monotherapy AND the member has a medical reason as to why Cabometyx (cabozantinib) can not be initiated or continued OR in combination with Keytruda or Bavencio as first-line therapy. Advanced Thyroid Carcinoma: The member has a diagnosis of advanced/metastatic follicular carcinoma, oncocytic carcinoma, or papillary carcinoma and clinical trials are not available or appropriate AND The member has disease that is not responsive to radio-iodine treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INPEFA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Heart Failure and Cardiovascular Prevention. The member must have one of the following: Diagnosis of heart failure OR Diagnosis of type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors (e.g. obesity, dyslipidemia, hypertension) AND The member must have had previous treatment, intolerance, or contraindication to Jardiance (empagliflozin) and Farxiga (dapagliflozin).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INQOVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression on hypomethylators (e.g. azacitidine, decitabine).
Required Medical Information	Myelodysplastic Syndromes - Chronic Myelomonocytic Leukemia: The member has a diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo or secondary MDS OR chronic myelomonocytic leukemia (CMML) AND the member will be using Inqovi (decitabine and cedazuridine) as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INREBIC - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Inrebic (fedratinib).
Required Medical Information	Myelofibrosis: The member has a diagnosis of primary myelofibrosis or secondary myelofibrosis (i.e. post-polycythemia vera or post-essential thrombocythemia) AND The member has one of the following risk categories, as defined by accepted risk stratification tools for myelofibrosis (e.g. International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or DIPSS-PLUS): Intermediate-2 risk disease OR High-risk disease AND the member will be using Inrebic (fedratinib) as monotherapy AND The member has a medical reason as to why Jakafi (ruxolitinib) cannot be used.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INSULIN DEGLUDEC - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of type 1 or type 2 diabetes mellitus AND The member has had previous treatment or intolerance with at least one preferred insulin glargine product: Lantus, Lantus Solostar OR Toujeo AND insulin degludec (i.e. Tresiba).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INSULIN GLARGINE U-300 CONC - INSULIN PEN (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of type 1 or type 2 diabetes mellitus AND The member has had previous treatment or intolerance with at least one preferred insulin glargine product: Lantus, Lantus Solostar OR Toujeo AND insulin degludec (i.e. Tresiba).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INSULIN GLARGINE-YFGN - INSULIN PEN (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of type 1 or type 2 diabetes mellitus AND The member has had previous treatment or intolerance with at least one preferred insulin glargine product: Lantus, Lantus Solostar OR Toujeo AND insulin degludec (i.e. Tresiba).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INTRAROSA - INSERT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Dyspareunia: The member must be post-menopausal AND have vulvar and/or vaginal atrophy AND diagnosis of moderate to severe dyspareunia AND has had a previous treatment, intolerance, or contraindication to estradiol vaginal cream or Premarin vaginal cream.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INVEGA - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Bipolar Disorder, Acute Manic and Mixed Episodes: The member must have a diagnosis of bipolar disorder (acute manic and mixed episodes). The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole. Schizophrenia: The member must have a diagnosis of schizophrenia. The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Schizoaffective Disorder: The member must have a diagnosis of schizoaffective disorder. The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone.
Age Restriction	Age 18 or older for Bipolar Disorder, Acute Manic and Mixed Episodes and for Schizoaffective Disorder and age 12 or older for Schizophrenia.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

INVOKAMET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 diabetes mellitus: The member has a diagnosis of Type 2 diabetes mellitus AND the member has had previous treatment with, contraindication, or intolerance to: an empagliflozin AND dapagliflozin containing medication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INVOKAMET XR - TABLET,IMMED AND EXTEND REL BIPHASE 24HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 diabetes mellitus: The member has a diagnosis of Type 2 diabetes mellitus AND the member has had previous treatment with, contraindication, or intolerance to: an empagliflozin AND dapagliflozin containing medication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

INVOKANA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 diabetes mellitus: The member has a diagnosis of Type 2 diabetes mellitus AND the member has had previous treatment with, contraindication, or intolerance to: an empagliflozin AND dapagliflozin containing medication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ipratropium bromide - HFA AEROSOL WITH ADAPTER (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema. The member has had previous treatment, contraindication, or intolerance to Spiriva (i.e. Spiriva Handihaler, Spiriva Respimat). For Yupelri requests: BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IQIRVO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Biliary Cholangitis: The member has a diagnosis of primary biliary cholangitis (PBC) documented by TWO of the following: Elevated serum alkaline phosphatase level for at least 6 months, Positive antimitochondrial antibody test, or Liver biopsy AND The member does not have complete biliary obstruction AND The member has never had an episode of decompensated cirrhosis AND Prescribed by or in consultation with a gastroenterologist or hepatologist AND One of the following applies: The member has an intolerance to ursodiol OR The member has an inadequate response to an appropriately dosed one year trial of ursodiol defined as: Alkaline phosphatase greater than or equal to 1.67 times the upper limit of normal OR Total bilirubin greater than the upper limit of normal.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IRESSA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) AND the following applies: The member has a documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation AND The member is using Iressa (gefitinib) as monotherapy (without concomitant chemotherapy).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

ISORDIL TITRADOSE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ISTODAX - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on romidepsin.
Required Medical Information	Cutaneous T-cell Lymphoma (CTCL). Istodax (romidepsin) is being used to treat cutaneous T-cell lymphoma AND one of the following applies: the member will be using Istodax (romidepsin) as primary biologic systemic therapy OR the member has received at least one prior therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ISTURISA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cushing's Disease: The member has a diagnosis of Cushing's disease AND The member has had an inadequate response to pituitary surgery or pituitary surgery is not an option. Endogenous Hypercortisolemia: The member has a diagnosis of endogenous hypercortisolemia with Cushing's syndrome AND The member has had an inadequate response to surgery or surgery is not an option.
Age Restriction	The member is 18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ITOVEBI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression on a PIK3CA inhibitor (e.g., alpelisib).
Required Medical Information	Metastatic Breast Cancer - PIK3CA-mutated: The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND The disease is documented as PIK3CA-mutated, as detected by an FDA-test AND The member has endocrine resistant disease [i.e., disease progression on or after adjuvant endocrine therapy (e.g., anastrozole, tamoxifen)] AND Itovebi (inavolisib) will be given in combination with Ibrance (palbociclib) and fulvestrant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IWILFIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has had prior progression on Iwilfin (eflornithine). Member has been on therapy for more than two years.
Required Medical Information	High-Risk Neuroblastoma (HRNB): Member has diagnosis of high-risk neuroblastoma AND Member has had at least a partial response (or better) to prior multiagent, multimodality therapy including anti-GD2 immunotherapy (e.g., dinutuximab).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

IXEMPRA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced severe (CTC grade 3/4) hypersensitivity reaction to medications formulated with Cremophor EL or its derivatives (e.g. polyoxyethylated castor oil). Ixempra (ixabepilone) should be discontinued after disease progression.
Required Medical Information	Breast Cancer: The member has a diagnosis of locally advanced or metastatic breast cancer AND one of the following: When used as monotherapy: the member has disease that is refractory or resistant to an anthracycline (e.g. Doxorubicin), a taxane (e.g. paclitaxel) and Xeloda (capecitabine) OR When used in conjunction with Xeloda (capecitabine) or 5-FU/fluorouracil: the member has disease that is refractory or resistant to both an anthracycline (e.g. Doxorubicin) and a taxane (e.g. paclitaxel) (or further anthracycline therapy is contraindicated).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

JADENU - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Platelet counts less than 50,000/mcL. (Per FDA label, Deferasirox is contraindicated in patients with platelets below 50,000).
Required Medical Information	Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload. Initial Request: The Member must meet ALL of the following criteria: Diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions. AND Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment). Continuation of Therapy Request: The Member must meet ALL of the following criteria: Ferritin level must be consistently above 500mcg/L (deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L.) Chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: The member must meet ALL of the following criteria: The member has a diagnosis of chronic iron overload with non-transfusion dependent thalassemia (NTDT) syndrome AND The member has liver iron (Fe) concentration of at least 5mg/gm of liver dry weight AND The member has a serum ferritin greater than 300 mcg/L. Continuation of Therapy Request: The Member must meet ALL of the following criteria: Liver iron (Fe) concentration of at least 3 mg/gm of liver dry weight AND Serum ferritin greater than 300 mcg/L.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan Year Duration. Reauthorization: Plan year duration.
Other Criteria	
Part B Prerequisite	0

JADENU SPRINKLE - GRANULES IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Platelet counts less than 50,000/mcL. (Per FDA label, Deferasirox is contraindicated in patients with platelets below 50,000).
Required Medical Information	Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload. Initial Request: The Member must meet ALL of the following criteria: Diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions. AND Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment). Continuation of Therapy Request: The Member must meet ALL of the following criteria: Ferritin level must be consistently above 500mcg/L (deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L.) Chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: The member must meet ALL of the following criteria: The member has a diagnosis of chronic iron overload with non-transfusion dependent thalassemia (NTDT) syndrome AND The member has liver iron (Fe) concentration of at least 5mg/gm of liver dry weight AND The member has a serum ferritin greater than 300 mcg/L. Continuation of Therapy Request: The Member must meet ALL of the following criteria: Liver iron (Fe) concentration of at least 3 mg/gm of liver dry weight AND Serum ferritin greater than 300 mcg/L.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan Year Duration. Reauthorization: Plan year duration.
Other Criteria	
Part B Prerequisite	0

JAKAFI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Jakafi (ruxolitinib).
Required Medical Information	Myelofibrosis. The member has a documented diagnosis of primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis AND The member has one of the following risk categories, as defined by International Prognostic Scoring System (IPSS): Symptomatic low risk disease OR Symptomatic intermediate-1 risk disease OR Intermediate-2 risk disease OR High risk disease. The member will be using Jakafi (ruxolitinib) as monotherapy (excludes medically necessary supportive agents). Polycythemia Vera: The member has a diagnosis of polycythemia vera AND The member has not achieved treatment goals, has an intolerance, or contraindication to hydroxyurea. Acute Graft Versus Host Disease: The member has a diagnosis of steroid-refractory acute graft versus host disease. Chronic Graft Versus Host Disease (cGVHD): The member has a diagnosis of chronic graft-versus-host disease (cGVHD) AND the member has been unable to achieve treatment goals with at least one prior line of systemic therapy (e.g., corticosteroids).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

JALYN - CAPSULE,EXTENDED RELEASE MULTIPHASE 24HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

JASCAYD - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Idiopathic Pulmonary Fibrosis (IPF): Documentation of Pulmonary Fibrosis by one of the following: Computed tomography (CT) scan is indicative of usual interstitial pneumonia (UIP), Surgical lung biopsy. Has not had clinically significant environmental exposure or explanation for pulmonary fibrosis or interstitial lung disease (e.g., drugs, asbestos, beryllium, radiation, domestic birds, sarcoidosis, hypersensitivity pneumonitis, bronchiolitis, obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, or cancer) AND Has had previous treatment, contraindication, or intolerance to Ofev (nintedanib) OR pirfenidone (tablet or capsule). Progressive Pulmonary Fibrosis (PPF): Diagnosis of an Interstitial Lung Disease [ILD] with pulmonary fibrosis (e.g. Hypersensitivity pneumonitis, Autoimmune ILD, Rheumatoid arthritis-associated ILD [RA-ILD], Systemic Sclerosis-associated ILD [SSc-ILD], Mixed Connective Tissue Disease-associated ILD, Idiopathic non-specific interstitial pneumonia, Unclassifiable Idiopathic Interstitial Pneumonia, Exposure-related ILDs, Sarcoidosis with Fibrosing ILD) confirmed by one of the following: Computed Tomography (CT) with evidence of fibrosis or Lung biopsy. Member has a progressive phenotype confirmed by one of the following prior to therapy initiation: A relative decline in FVC of at least 10% OR Worsening respiratory symptoms OR Increased extent of fibrotic change on CT scan. Has had previous treatment, contraindication, or intolerance to Ofev (nintedanib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

JATENZO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

javygtor - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Phenylketonuria (PKU): The member has a diagnosis of PKU AND for brand requests the member has had previous treatment, contraindication, or intolerance to generic sapropterin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

JAYPIRCA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Mantle cell lymphoma: The member has a diagnosis of mantle cell lymphoma AND the member has relapsed or refractory disease AND the member has received at least two prior lines of systemic therapy, including a BTK inhibitor AND the member will be using Jaypirca (pirtobrutinib) as monotherapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member has a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) AND the member has received at least 2 prior lines of therapy, including BTK inhibitor and a BCL-2 inhibitor AND the member will be using Jaypirca (pirtobrutinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

jaythari - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Duchenne Muscular Dystrophy: The member must have a diagnosis of Duchenne Muscular Dystrophy confirmed by dystrophin genetic testing AND the member has onset of muscle weakness before 5 years of age AND the member has had previous treatment of prednisone for at least 6 months and experienced one of the following: undesirable weight gain defined as more than 20% of body weight gain increase from baseline that required prednisone dose reduction OR a severe behavioral adverse effect (e.g., unmanageable irritation, aggression) that required prednisone dose reduction.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

JEMPERLI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression while on or following prior anti-PD-1/PD-L1 therapy (e.g., nivolumab, pembrolizumab).
Required Medical Information	Endometrial cancer (2nd line or beyond): The member has diagnosis of recurrent or advanced endometrial cancer AND The member has documented dMMR endometrial cancer AND The member has progressed on prior platinum containing regimen AND Jemperli (dostarlimab-gxly) is administered as monotherapy as subsequent therapy. Solid tumors (dMMR): The member has a diagnosis of unresectable or metastatic documented mismatch repair deficient (d-MMR) solid tumors AND the member has disease that has progressed on prior therapy with no alternative treatments AND Jemperli (dostarlimab-gxly) is administered as monotherapy. Endometrial cancer (frontline therapy): The member has diagnosis of primary advanced or recurrent endometrial cancer AND Jemperli (dostarlimab-gxly) will be used in combination with carboplatin and paclitaxel, followed by maintenance therapy as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration. Endometrial cancer (frontline therapy) only: Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

JEVTANA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Jevtana should not be administered to patients with neutrophils less than or equal to 1,500/mm ³ . Jevtana should not be given to patients with hepatic impairment (total bilirubin greater than 3 x ULN. Concomitant use with abiraterone acetate, Yonsa, or Xtandi.
Required Medical Information	Hormone-Refractory Metastatic Prostate Cancer. The member must have a diagnosis of hormone-refractory metastatic prostate cancer. The member must have previously been treated with a docetaxel-containing treatment regimen. The member must be taking Jevtana in combination with concurrent corticosteroid (e.g., dexamethasone, prednisone).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

JOBEVNE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Malignant Pleural Mesothelioma, Soft Tissue Sarcoma, Recurrent Primary CNS Tumor (including Glioblastoma multiforme), Renal Cell Carcinoma, Non-small cell lung cancer (non-squamous cell histology): The member has experienced disease progression while on or following a bevacizumab product. Metastatic colorectal cancer: A bevacizumab product may not be used in conjunction with Vectibix (panitumumab) or Erbitux (cetuximab).
Required Medical Information	For Avastin (bevacizumab), Alymsys (bevacizumab-maly), Jobevne (bevacizumab-nwgd), and Vegzelma (bevacizumab-adcd) oncology requests: member must have an intolerance or contraindication with Mvasi or Zirabev. Metastatic colorectal cancer: metastatic colorectal cancer AND 1 of the following applies: using a bevacizumab product in combo with fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemo for 1st or 2nd-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemo for 2nd-line therapy in patients who have progressed on 1st-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). NSCLC with non-squamous cell histology AND the disease is unresectable, locally advanced, recurrent, or metastatic AND A bevacizumab product will be used as part of a supported combination chemotherapy. Hepatocellular carcinoma: unresectable or metastatic HCC AND a bevacizumab product will be used as 1st line therapy in combo with an atezolizumab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

JOBEVNE - VIAL (ML)

Other Criteria	Renal cell carcinoma: Member has RCC and a bevacizumab product will be used in combo with interferon alpha. Recurrent Primary CNS Tumor (including Glioblastoma multiforme): Diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND a bevacizumab product is being used as a single agent or in combo with irinotecan, carmustine, lomustine or temozolomide AND the member does not have a CNS hemorrhage. Soft Tissue Sarcoma: One of the following applies: Diagnosis of angiosarcoma AND a bevacizumab product is being used as a single agent OR The member has a diagnosis of solitary fibrous tumor and a bevacizumab product is being used in combo with temozolomide. Macular Retinal Edema. Avastin is being used to treat central or branch retinal vein occlusion with macular retinal edema. Cervical Cancer: member has recurrent, or metastatic cervical cancer AND A bevacizumab product will be used as part of a supported combination therapy. Endometrial Cancer: The member has a diagnosis of endometrial cancer AND One of the following applies: The member has stage III-IV disease or recurrent disease AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, followed by maintenance with a bevacizumab product maintenance OR The member has recurrent disease AND a bevacizumab product monotherapy will be used as second-line or subsequent therapy if not previously used. Malignant Pleural Mesothelioma. Diagnosis of unresectable malignant pleural mesothelioma and a bevacizumab product will be used in combo with cisplatin and pemetrexed or carboplatin and pemetrexed followed by maintenance with a bevacizumab product (for responders). Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer AND One of the following applies: The disease is recurrent, platinum-resistant AND a bevacizumab product will be used in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan AND the member has not received more than 2 prior chemotherapy regimens OR The disease is recurrent, platinum-sensitive AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, or in combination with carboplatin and gemcitabine, followed by a bevacizumab product monotherapy AND The disease is stage III or IV AND initial surgical resection was completed AND a bevacizumab product will be used in combo with carboplatin and paclitaxel, followed by a bevacizumab product monotherapy OR . Age Related Macular Degeneration (Avastin requests only): Avastin (bevacizumab) is being used to treat age related macular degeneration. Diabetic Macular Edema (Avastin requests only): Avastin (bevacizumab) is being used to treat diabetic macular edema.
Part B Prerequisite	0

JOENJA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Activated phosphoinositide 3-kinase delta (PI3Kd) syndrome (APDS) - Initial: Confirmed APDS-associated PI3Kd mutation with documented variant in either PIK3CD or PIK3R1 AND medication is being prescribed by an immunologist, hematologist/oncologist, pulmonologist, allergist, or gastroenterologist. Activated phosphoinositide 3-kinase delta (PI3Kd) syndrome (APDS) - Continuation: Confirmation of clinical benefit of the manifestations of APDS (e.g. frequency of oto-sino-pulmonary infections, decrease in lymphoproliferation, improved organ function, etc.).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: 6 months. Continuation: Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

JOURNAVX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Pain: Member has moderate to severe acute pain AND Member has had previous treatment without adequate pain relief with at least one non-opioid drug from any of the following classes: Nonsteroidal anti-inflammatory drugs (e.g. ibuprofen, naproxen, diclofenac, celecoxib, indomethacin) OR Gabapentinoids (eg. gabapentin, pregabalin) AND Treating physician attests that opioids are not an appropriate therapy for the member (e.g. is at risk of opioid dependency with short-term use and/or adverse effects) OR Member has had previous treatment without adequate pain relief with at least one opioid-containing drug product (e.g. hydrocodone bitartrate - acetaminophen, tramadol 50mg tablet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	180 days
Other Criteria	
Part B Prerequisite	0

JUBLIA - SOLUTION WITH APPLICATOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Onychomycosis: The member has a diagnosis of onychomycosis of the toenails caused by Trichophyton rubrum or Trichophyton mentagrophytes AND Member has had previous treatment, contraindication, or intolerance to oral terbinafine and at least one of the following: itraconazole, ciclopirox nail solution, griseofulvin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

JUXTAPID - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Homozygous Familial Hypercholesteremia: Diagnosis of definite homozygous familial hypercholesteremia as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the low density lipoprotein (LDL) receptor, Apolipoprotein B, PCSK9, or autosomal recessive hypercholesterolemia (ARH) adaptor protein gene locus OR An untreated LDL-C greater than 400 mg/dL (10.3 mmol/L) with at least one of the following: Cutaneous or tendonous xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering therapy consistent with heterozygous familial hypercholesteremia in both parents (e.g. untreated LDL-C greater than or equal to 190 mg/dL (4.9 mmol/L))) AND Member must meet the following criteria: Must have had previous treatment, intolerance or contraindication to Repatha (evolocumab) AND Documentation of initiating a low fat diet (less than 20% of energy from fat) and daily supplementation with Vit E, linoleic acid, and omega-3 fatty acids [alpha-linolenic acid (ALA), eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA)] prior to starting Juxtapid.
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

JYLAMVO - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Lymphoblastic Leukemia (ALL): The member has a diagnosis of acute lymphoblastic leukemia AND The member will be using Jylamvo (methotrexate) as part of combination chemotherapy maintenance regimen AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Mycosis Fungoides: The member has a diagnosis of mycosis fungoides (cutaneous T-cell lymphoma) AND The member will be using Jylamvo (methotrexate) as a single agent or as part of combination chemotherapy regimen AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Non-Hodgkin lymphomas: The member has a diagnosis of non-Hodgkin lymphoma AND The member will be using Jylamvo (methotrexate) as part of a metronomic combination chemotherapy regimen AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Rheumatoid Arthritis: The member has a diagnosis of Rheumatoid Arthritis AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Psoriasis: The member has a diagnosis of severe psoriasis AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. Polyarticular Juvenile Idiopathic Arthritis: The member has a diagnosis of polyarticular juvenile idiopathic arthritis AND The member has had previous treatment, intolerance or documented difficulty swallowing generic methotrexate tablets. B vs D coverage determination may also be required.
Age Restriction	Mycosis Fungoides, Non-Hodgkin lymphomas, Rheumatoid Arthritis, and Psoriasis: The member must be 18 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

JYNARQUE - TABLET, SEQUENTIAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Autosomal Dominant Polycystic Kidney Disease. Has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) AND Must be at risk of rapidly progressive disease (e.g. advanced stage kidney disease according to age, hypertension before age 35, enlarged kidneys) AND Must have CKD stage 2 - 4 AND Medication is being used to slow kidney function decline.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KADCYLA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Kadcyla (ado-trastuzumab emtansine. Use in the adjuvant setting. Members on concomitant trastuzumab product, Tykerb (lapatinib), or Perjeta (pertuzumab).
Required Medical Information	Metastatic Breast Cancer. The member has a diagnosis of metastatic breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC 2+/ISH positive) AND the member is using Kadcyla (ado-trastuzumab emtansine) as monotherapy AND the member has received prior therapy with a trastuzumab product and a taxane (eg. paclitaxel, docetaxel), separately or in combination and one of the following applies: Received prior treatment for metastatic disease. Recurrence occurred during or within six months of completing adjuvant therapy. Early Breast cancer: The member has a diagnosis of early HER 2 positive breast (e.g., defined as IHC 3+ or IHC 2+/ISH positive) AND the member has received neoadjuvant taxane (e.g. paclitaxel) and trastuzumab containing regimen AND the member is receiving Kadcyla (ado-trastuzumab emtansine) as adjuvant treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KALYDECO - GRANULES IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis: The member must meet ALL of the following criteria: Diagnosis of Cystic Fibrosis AND Prior lab testing with documentation of a mutation in the CFTR gene that is responsive to therapy based on clinical literature and/or in vitro assay data AND Previous treatment, contraindication, or intolerance to Trikafta.
Age Restriction	
Prescriber Restriction	The member is being treated by or in consultation with a specialist (e.g. pulmonologist).
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KANJINTI - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Herceptin (trastuzumab), Ogivri, Herzuma or Ontruzant requests: member must have an intolerance or contraindication Trazimera (trastuzumab-qyyp) OR Kanjinti (trastuzumab-anns) and meets below criteria: Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive). Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

KANUMA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Lysosomal Acid Lipase Deficiency(LAL-D):The member must have a diagnosis of lysosomal Acid Lipase Deficiency confirmed by one of the following tests: Dried Blood Spot (DBS) test, leucocyte testing, OR genetic testing.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA
Part B Prerequisite	0

KAZANO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KEPPRA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KEPPRA XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KERENDIA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic kidney disease associated with type 2 diabetes: The member has a diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D) AND The member is currently receiving, unless contraindicated or intolerant, the maximally tolerated dose of: Either an angiotensin-converting enzyme inhibitor (e.g. Lisinopril) OR an angiotensin receptor blocker (e.g. losartan). Heart Failure: The member has a diagnosis of heart failure AND has a left ventricular ejection fraction greater than or equal to 40%.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

KESIMPTA PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease OR the member has a diagnosis of a clinically isolated syndrome (CIS).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ketoconazole - TABLET

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Systemic Fungal Infection: member has a diagnosis of a systemic fungal infection (i.e., blastomycosis, coccidioidomycosis, histoplasmosis, paracoccidioidomycosis, chromomycosis). Prophylaxis - Transplanted Organ Rejection: member has a transplanted organ AND member will concurrently receive immunosuppressant therapy with cyclosporine.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

ketorolac - SPRAY, NON-AEROSOL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Pain. Has a diagnosis of moderate to moderately-severe acute pain. Will be using Sprix for no more than 5 days. Has had a trial with at least TWO of the following oral products: ketorolac, meloxicam, celecoxib capsule, naproxen, ibuprofen, diclofenac, or tramadol 50 mg tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	One month duration
Other Criteria	
Part B Prerequisite	0

KEVEYIS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Periodic paralysis: The member must have a diagnosis of primary hyperkalemic or hypokalemic periodic paralysis, or variants of periodic paralysis (i.e. Paramyotonia Congenita, Andersen-Tawil Syndrome) AND The member has had previous treatment, contraindication, or intolerance with acetazolamide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

KEVZARA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polymyalgia Rheumatica: The member must have a diagnosis of polymyalgia rheumatica AND The member has had prior therapy with or intolerance to a single corticosteroid (e.g. prednisone, methylprednisolone) or contraindication to all corticosteroids. Polyarticular Juvenile Idiopathic Arthritis: The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis AND The member must weigh 63 kg or greater AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq.
Age Restriction	Must be 18 years of age or older for moderate to severe Rheumatoid Arthritis and Polymyalgia Rheumatica.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KEYTRUDA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression while on or following prior anti-PD-1/PD-L1 therapy (e.g., nivolumab, atezolizumab) (applicable to all indications except Head and Neck Squamous Cell Carcinoma perioperative). Member requiring urgent cytoreductive therapy (applicable to PMBCL only). Member not to exceed one year of total adjuvant treatment (applicable to melanoma, NSCLC, and renal cell carcinoma only). Total treatment duration of Keytruda (pembrolizumab) is more than 12 months (Head and Neck Squamous Cell Carcinoma perioperative only).
Required Medical Information	Melanoma: unresectable or metastatic melanoma OR melanoma OR stage IIB, IIC, or III melanoma AND as monotherapy for adjuvant treatment after complete resection with involvement of lymph node(s). NSCLC-1st Line: metastatic NSCLC AND 1 of the following applies: disease with PD-L1 expression [TPS greater than or equal to 1%] with no EGFR or ALK genomic tumor aberrations and as 1st line AND tumor expresses PD-L1 as determined by an FDA-approved test AND used as monotherapy OR nonsquamous histology with no EGFR or ALK genomic tumor aberrations and in combo with pemetrexed and carboplatin or cisplatin as 1st line therapy followed by Keytruda maintenance in combo with pemetrexed OR squamous histology and used in combo with carboplatin and paclitaxel or Abraxane as 1st line followed by Keytruda maintenance OR stage III NSCLC and not candidate for surgical resection or definitive chemoradiation AND PD-L1 expression with no EGFR or ALK genomic tumor aberrations and as 1st line AND Tumor expresses PD-L1 as determined by an FDA-approved test AND as monotherapy. NSCLC-Subsequent: metastatic NSCLC AND progression on or following chemo and EGFR inhibitor, if EGFR mutation positive or ALK inhibitor, if ALK positive AND Tumor expresses PD-L1 as determined by an FDA-approved test AND as monotherapy. Head-Neck Cancer: recurrent or metastatic non-nasopharyngeal head and neck squamous cell carcinoma AND 1 of following: disease progression on platinum-containing chemo and as monotherapy OR in combo with platinum and 5-FU for 1st line treatment OR monotherapy in 1st line and disease expresses CPS score greater than or equal to 1 as detected by an FDA-approved test. Hodgkin's Lymphoma-Adult: as monotherapy for refractory or relapsed disease. Hodgkin's Lymphoma-Peds: monotherapy and 1 of following: Refractory disease OR Relapsed after 2 or more lines of prior therapy. CSCC: recurrent or metastatic CSCC AND disease is not amenable to curative surgery or radiation AND used as a monotherapy.
Age Restriction	Stage IIB, IIC, or III melanoma - member is 12 years of age or older.

KEYTRUDA - VIAL (ML)

Prescriber Restriction	Licensed Practitioner
Coverage Duration	NSCLC (Neoadjuvant therapy): 3 months duration. All other indications: 6 months duration.

KEYTRUDA - VIAL (ML)

Other Criteria	MSI-High/d-MMR Solid tumors: unresectable or metastatic documented microsatellite instability-high or mismatch repair deficient solid tumors (excluding pediatric patients with MSI-H central nervous system cancers) AND 1 of the following: disease that progressed on prior therapy with no alternative treatments and as monotherapy OR colorectal cancer AND 1 of the following: Keytruda as monotherapy and as subsequent therapy after progression on fluoropyrimidine, oxaliplatin, and irinotecan or 1st line as monotherapy in unresectable or metastatic colorectal cancer. Urothelial Cancer: locally advanced or metastatic urothelial cancer AND 1 of the following: initial therapy in members ineligible to receive platinum containing chemo OR as subsequent monotherapy after disease progression within 12 months of neoadjuvant or adjuvant chemo OR in combination with Padcev (enfortumab vedotin-ejfv) in the front-line setting. Cervical Cancer: recurrent or metastatic cervical cancer AND disease progression on or after chemo AND disease expresses CPS score greater than or equal to 1 as determined by an FDA approved test AND as monotherapy OR persistent, recurrent, or metastatic cervical cancer AND cancer express CPS score of greater than or equal to 1 as determined by an FDA approved test and will be used with chemo, with or without bevacizumab, as 1st line therapy OR diagnosis of FIGO 2014 Stage III-IVA cervical cancer AND will be used with chemo, followed by monotherapy. Primary Mediastinal Large B-Cell Lymphoma [Adults and pediatrics]: relapsed or refractory disease after 2 or more prior lines of treatment AND as monotherapy. Merkel cell carcinoma-Adult and pediatric: recurrent locally advanced or metastatic merkel cell carcinoma AND as monotherapy. HCC: has prior therapy with a 1st line therapy (e.g., sorafenib) AND as monotherapy. RCC: advanced or metastatic RCC AND in combo with Inlyta or Lenvima as 1st line therapy. Esophageal Cancer: recurrent locally advanced or metastatic squamous cell carcinoma of the esophagus AND disease expresses PD-L1 as determined by an FDA approved test AND given as subsequent therapy as a single agent. Endometrial cancer: metastatic or recurrent endometrial cancer AND not MSI-H or pMMR as determined by an FDA approved test AND not candidate for surgery or radiation AND has experienced disease progression on prior systemic therapy AND given in combo with Lenvima as subsequent therapy. NMIBC with carcinoma in situ AND ineligible for or has elected not to undergo cystectomy AND has BCG-unresponsive disease, defined as persistent or recurrent high-grade bladder cancer within 6 months of intravesical BCG therapy AND as monotherapy. TMB-H Solid tumors: unresectable or metastatic solid tumors with documented TMB-H [greater than or equal to 10 mutations/megabase] (excluding pediatric patients with TMB-H central nervous system cancers) AND disease progressed on prior therapy with no alternative treatments AND given as monotherapy.
Part B Prerequisite	0

KEYTRUDA QLEX - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression while on or following prior anti-PD-1/PD-L1 therapy (e.g., nivolumab, atezolizumab) (applicable to all indications except Head and Neck Squamous Cell Carcinoma perioperative). Member not to exceed one year of total adjuvant treatment (applicable to melanoma, NSCLC, and renal cell carcinoma only). Total treatment duration of Keytruda (pembrolizumab) is more than 12 months (Head and Neck Squamous Cell Carcinoma perioperative only).
Required Medical Information	Melanoma: unresectable or metastatic melanoma OR melanoma OR stage IIB, IIC, or III melanoma AND as monotherapy for adjuvant treatment after complete resection with involvement of lymph node(s). NSCLC-1st Line: metastatic NSCLC AND 1 of the following applies: disease with PD-L1 expression [TPS greater than or equal to 1%] with no EGFR or ALK genomic tumor aberrations and as 1st line AND tumor expresses PD-L1 as determined by an FDA-approved test AND used as monotherapy OR nonsquamous histology with no EGFR or ALK genomic tumor aberrations and in combo with pemetrexed and carboplatin or cisplatin as 1st line therapy followed by pembrolizumab product maintenance in combo with pemetrexed OR squamous histology and used in combo with carboplatin and paclitaxel or Abraxane as 1st line followed by pembrolizumab product maintenance OR stage III NSCLC and not candidate for surgical resection or definitive chemoradiation AND PD-L1 expression with no EGFR or ALK genomic tumor aberrations and as 1st line AND Tumor expresses PD-L1 as determined by an FDA-approved test AND as monotherapy. NSCLC-Subsequent: metastatic NSCLC AND progression on or following chemo and EGFR inhibitor, if EGFR mutation positive or ALK inhibitor, if ALK positive AND Tumor expresses PD-L1 as determined by an FDA-approved test AND as monotherapy. Head-Neck Cancer: recurrent or metastatic non-nasopharyngeal head and neck squamous cell carcinoma AND 1 of following: disease progression on platinum-containing chemo and as monotherapy OR in combo with platinum and 5-FU for 1st line treatment OR monotherapy in 1st line and disease expresses CPS score greater than or equal to 1 as detected by an FDA-approved test. CSCC: recurrent or metastatic CSCC AND disease is not amenable to curative surgery or radiation AND used as a monotherapy.
Age Restriction	Stage IIB, IIC, or III melanoma - member is 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	NSCLC (Neoadjuvant therapy): 3 months duration. All other indications: 6 months duration.

KEYTRUDA QLEX - VIAL (ML)

Other Criteria	MSI-High/d-MMR Solid tumors: unresectable or metastatic documented microsatellite instability-high or mismatch repair deficient solid tumors (excluding pediatric patients with MSI-H central nervous system cancers) AND 1 of the following: disease that progressed on prior therapy with no alternative treatments and as monotherapy OR colorectal cancer AND 1 of the following: pembrolizumab product as monotherapy and as subsequent therapy after progression on fluoropyrimidine, oxaliplatin, and irinotecan or 1st line as monotherapy in unresectable or metastatic colorectal cancer. Urothelial Cancer: locally advanced or metastatic urothelial cancer AND 1 of the following: initial therapy in members ineligible to receive platinum containing chemo OR as subsequent monotherapy after disease progression within 12 months of neoadjuvant or adjuvant chemo OR in combination with Padcev (enfortumab vedotin-ejfv) in the front-line setting. Cervical Cancer: recurrent or metastatic cervical cancer AND disease progression on or after chemo AND disease expresses CPS score greater than or equal to 1 as determined by an FDA approved test AND as monotherapy OR persistent, recurrent, or metastatic cervical cancer AND cancer express CPS score of greater than or equal to 1 as determined by an FDA approved test and will be used with chemo, with or without bevacizumab, as 1st line therapy OR diagnosis of FIGO 2014 Stage III-IVA cervical cancer AND will be used with chemo, followed by monotherapy. Merkel cell carcinoma-Adult and pediatric: recurrent locally advanced or metastatic merkel cell carcinoma AND as monotherapy. HCC: has prior therapy with a 1st line therapy (e.g., sorafenib) AND as monotherapy. RCC: advanced or metastatic RCC AND in combo with Inlyta or Lenvima as 1st line therapy. Esophageal Cancer: recurrent locally advanced or metastatic squamous cell carcinoma of the esophagus AND disease expresses PD-L1 as determined by an FDA approved test AND given as subsequent therapy as a single agent. Endometrial cancer: metastatic or recurrent endometrial cancer AND not MSI-H or dMMR as determined by an FDA approved test AND not candidate for surgery or radiation AND has experienced disease progression on prior systemic therapy AND given in combo with Lenvima as subsequent therapy. NMIBC with carcinoma in situ AND ineligible for or has elected not to undergo cystectomy AND has BCG-unresponsive disease, defined as persistent or recurrent high-grade bladder cancer within 6 months of intravesical BCG therapy AND as monotherapy. TMB-H Solid tumors: unresectable or metastatic solid tumors with documented TMB-H [greater than or equal to 10 mutations/megabase] (excluding pediatric patients with TMB-H central nervous system cancers) AND disease progressed on prior therapy with no alternative treatments AND given as monotherapy.
Part B Prerequisite	0

KHAPZORY - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with pernicious anemia or megaloblastic anemia secondary to the lack of vitamin B12.
Required Medical Information	Osteosarcoma: The member is being treated with high dose methotrexate for osteosarcoma. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy OR due to leucovorin calcium formulation necessitating a change in therapy. Impaired methotrexate elimination or inadvertent over dosage of folic acid antagonists. The patient has been treated with methotrexate or other folic acid antagonist and is currently exhibiting signs of toxicity likely due to aforementioned therapy. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy. Advanced Metastatic Colorectal Cancer. The member has advanced metastatic colorectal cancer. The member is receiving palliative treatment with combination chemotherapy with 5-fluorouracil AND The member has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or has experienced documented side effects due to leucovorin calcium formulation necessitating a change in therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

KHINDIVI - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pediatric Adrenocortical Insufficiency: The member has a diagnosis of pediatric adrenocortical insufficiency AND The member has a documented contraindication to hydrocortisone tablets.
Age Restriction	
Prescriber Restriction	
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KIMMTRAK - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Kimmtrak (tebentafusp-tebn).
Required Medical Information	Metastatic Uveal Melanoma: the member has a diagnosis of unresectable or metastatic uveal melanoma AND the member has documentation of HLA-A 02:01 positive disease by assay results AND Kimmtrak (tebentafusp-tebn) will be used as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

KINERET - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has had previous treatment, contraindication, or intolerance to two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Cryopyrin Associated Periodic Syndromes: The member must have diagnosis on neonatal-onset multisystem inflammatory disease (NOMID). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): The member has a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA).
Age Restriction	Must be 18 years of age or older for Rheumatoid Arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KISQALI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, abemaciclib). Early Breast Cancer: Member exceeds three years of total Kisqali (ribociclib) based treatment.
Required Medical Information	Breast Cancer-Combination with Aromatase Inhibitors. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy. Breast Cancer- Combination with fulvestrant. The member has a diagnosis of advanced or metastatic hormone receptor-positive and human epidermal growth factor receptor 2-negative breast cancer AND the member will be using Kisqali (ribociclib) in combination with fulvestrant. Early Breast Cancer-Combination with Aromatase Inhibitor: The member has a diagnosis of hormone receptor (HR) - positive and human epidermal growth factor receptor 2 (HER2) - negative, stage II or III early breast cancer at high risk of recurrence AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as adjuvant treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

KISQALI FEMARA CO-PACK - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, abemaciclib). Early Breast Cancer: Member exceeds three years of total Kisqali (ribociclib) based treatment.
Required Medical Information	Breast Cancer-Combination with Aromatase Inhibitors. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy. Breast Cancer- Combination with fulvestrant. The member has a diagnosis of advanced or metastatic hormone receptor-positive and human epidermal growth factor receptor 2-negative breast cancer AND the member will be using Kisqali (ribociclib) in combination with fulvestrant. Early Breast Cancer-Combination with Aromatase Inhibitor: The member has a diagnosis of hormone receptor (HR) - positive and human epidermal growth factor receptor 2 (HER2) - negative, stage II or III early breast cancer at high risk of recurrence AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as adjuvant treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

KITABIS PAK - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with Pseudomonas aeruginosa. For Brand Requests: Prior therapy, intolerance to, or contraindication to generic tobramycin for inhalation. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

KLISYRI (250 MG) - OINTMENT IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Actinic Keratosis: The member has a diagnosis of actinic keratosis. The member has trial, intolerance, or contraindication to generic imiquimod 5% cream or topical fluorouracil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KLISYRI (350 MG) - OINTMENT IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Actinic Keratosis: The member has a diagnosis of actinic keratosis. The member has trial, intolerance, or contraindication to generic imiquimod 5% cream or topical fluorouracil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KLONOPIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KOMZIFTI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

KORLYM - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hyperglycemia secondary to hypercortisolism. Diagnosis of endogenous Cushing's syndrome. AND Type 2 diabetes mellitus or glucose intolerance. AND Failed surgery or are not candidates for surgery.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KOSELUGO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experienced disease progression on Koselugo (selumetinib)
Required Medical Information	Neurofibromatosis type 1: The member has a diagnosis of neurofibromatosis type 1 which is symptomatic, inoperable plexiform neurofibromas and Koselugo (selumetinib) is given as a monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KRAZATI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experienced disease progression on KRAS G12C inhibitor (e.g., sotorasib, adagrasib).
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic NSCLC AND the NSCLC has documented KRAS G12C mutation AND the member has experienced disease progression on one prior therapy AND Krazati (adagrasib) will be given as monotherapy. Colorectal Cancer (CRC): The member has a diagnosis of locally advanced or metastatic colorectal cancer (CRC) AND the CRC has a documented KRAS G12C mutation AND the member has received prior systemic treatment with chemotherapy [fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine), oxaliplatin, irinotecan] AND Krazati (adagrasib) will be given in combination with Erbitux (cetuximab).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

KUVAN - TABLET, SOLUBLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Phenylketonuria (PKU): The member has a diagnosis of PKU AND for brand requests the member has had previous treatment, contraindication, or intolerance to generic sapropterin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

KYGEVVI - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

kymbee - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Duchenne Muscular Dystrophy: The member must have a diagnosis of Duchenne Muscular Dystrophy confirmed by dystrophin genetic testing AND the member has onset of muscle weakness before 5 years of age AND the member has had previous treatment of prednisone for at least 6 months and experienced one of the following: undesirable weight gain defined as more than 20% of body weight gain increase from baseline that required prednisone dose reduction OR a severe behavioral adverse effect (e.g., unmanageable irritation, aggression) that required prednisone dose reduction.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

KYPROLIS - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Kyprolis (carfilzomib).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of Multiple Myeloma AND The member is using Kyprolis (carfilzomib) as a single agent or in combination with dexamethasone for disease relapse or progressive disease OR the member will be using Kyprolis (carfilzomib) in combination with Pomalyst (pomalidomide) and dexamethasone and the member has received at least two prior therapies, including an immunomodulatory agent (e.g. thalidomide, lenalidomide, pomalidomide) and a proteasome inhibitor (e.g. bortezomib) (Omission of corticosteroid from regimen is allowed if intolerance/contraindication) AND the member has demonstrated disease progression on or within 60 days of completion of the last therapy OR The member will be using Kyprolis (carfilzomib) in combination with Revlimid (lenalidomide) and dexamethasone or in combination with cyclophosphamide and dexamethasone (Omission of corticosteroid from regimen is allowed if intolerance/contraindication) and one of the following applies: Is using as primary therapy OR Using for treatment of disease relapse (disease relapse must be after 6 months following primary chemotherapy with the same regimen) or progressive disease OR the member will be using Kyprolis (carfilzomib) in combination with CD38 inhibitor (e.g., daratumumab product, isatuximab) and dexamethasone and the member has received at least one prior line of therapy (Omission of corticosteroid from regimen is allowed if intolerance/contraindication).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Waldenstrom's Macroglobulinemia: The member has a diagnosis of Waldenstrom's macroglobulinemia AND Kyprolis (carfilzomib) will be used as a component of CaRD regimen (carfilzomib, rituximab, and dexamethasone) as primary therapy (Omission of corticosteroid from regimen is allowed if intolerance/contraindication) OR for relapsed disease (if CaRD previously used as primary therapy relapse must occur after 24 months).
Part B Prerequisite	0

LAMZEDE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-central nervous system manifestations of alpha-mannosidosis: The member has a diagnosis of alpha-mannosidosis requiring treatment for non-central nervous system manifestations.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

Ianreotide - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of acromegaly. The member has a diagnosis of acromegaly. The member has had an inadequate response to or cannot be treated with traditional therapies including surgery and/or radiation therapy. Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs): The member has a diagnosis of unresectable, well- or moderately-differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors. Carcinoid Syndrome: The member has a diagnosis of carcinoid syndrome with symptoms of flushing and/or diarrhea.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

lapatinib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Tykerb (lapatinib).
Required Medical Information	For brand Tykerb requests: Member must have an intolerance or contraindication to generic lapatinib AND member must meet clinical criteria below. Breast Cancer: The member has a diagnosis of HER2 (human epidermal growth factor receptor2) positive advanced or metastatic breast cancer AND The member had prior therapy, contraindication, or intolerance with an anthracycline (e.g. doxorubicin) and a taxane (e.g.paclitaxel)OR The member has a diagnosis of HER2 positive metastatic breast cancer AND Used as first line treatment in combination with an aromatase inhibitor (Femara/letrozole, Arimidex/anastrozole or Aromasin/exemestane) for hormone receptor positive disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

LASIX ONYU - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Edema: Diagnosis of chronic heart failure AND Has edema AND Must have previous treatment with a loop diuretic (e.g. furosemide tablets).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LATUDA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LAZCLUZE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND the NSCLC has a documented epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations AND Lazcluze (lazertinib) will be given in combination with an amivantamab product (i.e., Rybrevant, Rybrevant Faspro) in the first-line setting or as subsequent therapy (if not previously given).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ledipasvir-sofosbuvir - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Hepatitis C - Adults: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1,4,5 or 6 infection. HCV RNA level must be documented prior to therapy. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1, 4, 5 or 6 infection. HCV RNA must be documented prior to therapy. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. Chronic Hepatitis C Post Liver Transplant - Member must have received a liver transplant. Member must have experienced recurrent HCV infection post-transplant in the allograft liver. Member must have document genotype 1, 4, 5 or 6 infection. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. Chronic Hepatitis C With Decompensated Cirrhosis - Member must have diagnosis of chronic hepatitis C with decompensated cirrhosis. Member must have genotype 1, 4, 5 or 6 infection. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	8 to 24 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	
Part B Prerequisite	0

LEMTRADA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis: Member has diagnosis of a relapsing form of multiple sclerosis, to include relapsing remitting or active secondary progressive disease AND Member had an inadequate response to a minimum of two alternative MS therapies, one of which must be Ocrevus (ocrelizumab) or Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq)* *Previous treatment with Ocrevus or Ocrevus Zunovo does not apply for Medicare Part D requests. For Medicare Part B requests, the step therapy requirements do not apply if the request is continuation of prior therapy within the past 365 days.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

lenalidomide - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on lenalidomide.
Required Medical Information	Myelodysplastic Syndromes (MDS) with 5Q deletion. The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has a documented deletion 5q chromosomal abnormality AND the member has one of the following: Symptomatic Anemia (e.g. chronic fatigue, malaise) OR Transfusion-dependent anemia OR Anemia that is not controlled with erythroid stimulating agent. Myelodysplastic Syndromes (MDS) without 5Q deletion (non-5Q deletion). The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has no documented 5q deletion abnormality AND the member has one of the following: Symptomatic Anemia (e.g. chronic fatigue, malaise) OR Transfusion-dependent anemia OR Anemia that is not controlled with erythroid stimulating agent. Multiple Myeloma. Diagnosis of active Multiple Myeloma or Systemic Light Chain Amyloidosis. Primary induction OR for relapsed/refractory disease, lenalidomide therapy should be utilized in conjunction with dexamethasone if no contraindication. As maintenance therapy in patients with multiple myeloma following autologous hematopoietic stem cell transplantation. Chronic Lymphoid Leukemia. Diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND The member has relapsed or refractory disease AND The member will be using for third line or subsequent systemic therapy. Non-Hodgkin Lymphoma: The member has one of the following diagnoses: AIDS-related B-cell lymphoma, diffuse large B-cell lymphoma, mucosa-associated lymphoid tissue (MALT) lymphoma [either gastric or nongastric], marginal zone lymphoma, or mantle cell lymphoma AND The member has relapsed or refractory disease OR The member has a diagnosis of follicular lymphoma AND The member will use as first line therapy or for relapsed or refractory disease.
Part B Prerequisite	0

LENVIMA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Lenvima (lenvatinib).
Required Medical Information	Thyroid Cancer: The member has a diagnosis of locally recurrent or metastatic, progressive differentiated thyroid cancer (i.e. papillary carcinoma, follicular carcinoma or oncocytic carcinoma) AND The tumors are not responsive to radio-iodine treatment AND Lenvima (lenvatinib) will be used as monotherapy. Renal Cell Carcinoma. The member has a diagnosis of advanced renal cell carcinoma AND the member is using in combination with Afinitor (everolimus) AND the member has experienced intolerance on Cabometyx (cabozantinib) as second line therapy [e.g., severe hypertension/hypertensive crisis, cardiac failure, venous thromboembolic event within the last 6 months, arterial thromboembolic event within the last 12 months, severe hemorrhage, reversible posterior leukoencephalopathy, unmanageable fistula/GI perforation, nephrotic syndrome). Hepatocellular Carcinoma: The member has a diagnosis of unresectable carcinoma AND Lenvima (lenvatinib) will be given as a single agent as first line therapy. Endometrial cancer: The member has a diagnosis of metastatic or recurrent endometrial cancer AND The disease is not MSI-H or documented mismatch repair proficient (pMMR) as determined by an FDA-approved test AND The member is not a candidate for curative surgery or radiation AND The member has experienced disease progression on prior or following systemic therapy in any setting AND Lenvima (lenvatinib) will be given in combination with Keytruda (pembrolizumab) as subsequent therapy. Renal cell carcinoma- first line therapy: The member has a diagnosis of advanced renal cell carcinoma AND Lenvima (lenvatinib) will be given in combination with Keytruda (pembrolizumab) as first line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LEQEMBI IQLIK - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Mild cognitive impairment (MCI) or mild dementia due to Alzheimer's disease (AD): Member has a documented diagnosis of mild cognitive impairment (MCI) or mild dementia due to Alzheimer's disease (AD). One of the following applies: Member has stage 2, stage 3 or stage 4 Alzheimer's disease OR Member has a Mini Mental State Exam (MMSE) score between 22-30 (inclusive) and/or a Montreal Cognitive Assessment (MoCA) score between 17-30 (inclusive). Member has confirmed amyloid-beta pathology based on one of the following: positron emission tomography (PET) scan, cerebrospinal fluid (CSF) test, a blood-brain biomarker (BBM) test. The member has received the IV formulation over the past 18 months.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

LEQSELVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

LEQVIO - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Hyperlipidemia: Member has a diagnosis of primary hyperlipidemia (includes heterozygous familial hypercholesterolemia (HeFH), pure hypercholesterolemia, mixed hyperlipidemia, or clinical atherosclerotic cardiovascular disease) AND Leqvio (inclisiran) is used as adjunctive therapy to maximally tolerated high intensity statin (e.g. atorvastatin or rosuvastatin) in members who have failed to achieve goal LDL-C reduction OR the member is determined to have statin-associated muscle symptoms (SAMs) defined by any of the following: statin associated rhabdomyolysis OR member has failed to achieve goal LDL-C reduction due to SAMs despite lowering statin strength AND attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects AND the member has previous treatment, contraindication, or intolerance to Repatha (evolocumab).
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LEROCHOL - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

LETAIRIS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has a diagnosis of idiopathic pulmonary fibrosis.
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. For Brand Request: Member must have had previous treatment, intolerance, or contraindication to ambrisentan (generic Letairis).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LEUKINE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Routine use as prophylaxis in members/chemotherapy regimens without significant risk of febrile neutropenia. Same day administration with myelosuppressive chemotherapy or therapeutic radiation.
Required Medical Information	Allogeneic, HLA-matched related donors, Myeloid reconstitution: The member has recently completed an allogeneic bone marrow or peripheral-blood progenitor cell (PBPC) transplantation. Myeloid reconstitution in non-Hodgkin's lymphoma, Hodgkin's disease, and acute lymphoblastic lymphoma: The member has recently completed autologous bone marrow transplantation. Delay or failure of myeloid engraftment. The member must have had a bone marrow or peripheral-blood progenitor cell (PBPC) transplantation. Febrile Neutropenia Prophylaxis, In acute myelogenous leukemia following induction chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML).The member will receive Leukine (sargramostim) following either induction chemotherapy OR consolidation chemotherapy (in members in complete remission). Harvesting of peripheral blood stem cells: The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation or donating stem cells for an allogeneic or syngeneic PBSC transplant. Peripheral blood stem cell graft, Autologous, myeloid reconstitution following transplant in patients mobilized with granulocyte macrophage colony stimulating factor: The member has recently completed an autologous peripheral blood stem cell (PBSC) transplantation and was mobilized with GM-CSF. Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of non-therapeutic radiation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

LEUKINE - VIAL (EA)

Other Criteria	Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy: The member must have a diagnosis of non-myeloid malignancy (e.g., Solid Tumors) The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity. Neutropenia in Malignant melanoma: The member must have a diagnosis of malignant melanoma. Neutropenia in HIV/AIDS members: The member must have a diagnosis of HIV or AIDS with neutropenia. Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member must have a diagnosis of Hematopoietic Subsyndrome of Acute Radiation Syndrome.
Part B Prerequisite	0

leuprolide acetate (3 month) - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomyoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer: The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer AND The patient must be pre or perimenopausal. Recurrent Ovarian Cancer: Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	
Part B Prerequisite	0

levoleucovorin calcium - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with pernicious anemia or megaloblastic anemia secondary to the lack of vitamin B12.
Required Medical Information	Osteosarcoma: The member is being treated with high dose methotrexate for osteosarcoma. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy OR due to leucovorin calcium formulation necessitating a change in therapy. Impaired methotrexate elimination or inadvertent over dosage of folic acid antagonists. The patient has been treated with methotrexate or other folic acid antagonist and is currently exhibiting signs of toxicity likely due to aforementioned therapy. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy. Advanced Metastatic Colorectal Cancer. The member has advanced metastatic colorectal cancer. The member is receiving palliative treatment with combination chemotherapy with 5-fluorouracil AND The member has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or has experienced documented side effects due to leucovorin calcium formulation necessitating a change in therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LEXAPRO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LIBTAYO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Cutaneous squamous cell carcinoma, Basal cell carcinoma (BCC), and Non-small cell lung cancer (NSCLC): Member has experienced disease progression on or after prior PD-1/PD-L1 inhibitor (e.g., Keytruda).
Required Medical Information	Cutaneous squamous cell carcinoma. The member has a diagnosis of locally advanced or metastatic cutaneous squamous cell carcinoma (CSCC) AND the disease is not amenable to curative surgery or radiation AND Libtayo (cemiplimab-rwlc) is being used as a monotherapy. Cutaneous squamous cell carcinoma (adjuvant): The member has a diagnosis of cutaneous squamous cell carcinoma at high risk of recurrence AND Libtayo (cemiplimab-rwlc) will be used as monotherapy after surgery and radiation. Basal cell carcinoma (BCC): The member has locally advanced BCC or metastatic BCC AND the disease has been treated with prior hedgehog pathway inhibitor OR treatment with a hedgehog pathway inhibitor is inappropriate AND Libtayo (cemiplimab-rwlc) is given monotherapy. Non-small cell lung cancer (NSCLC): The member has a diagnosis of NSCLC without tumor aberrations (e.g., EGFR, ALK, ROS-1) AND The disease is locally advanced (not amenable to surgery or definitive chemoradiation) or metastatic AND The tumor expresses documented high PD-L1 expression [Tumor Proportion Score (TPS) greater than or equal to 50%] AND Libtayo (cemiplimab-rwlc) is given as monotherapy OR Libtayo (cemiplimab-rwlc) is given in combination with platinum based chemotherapy as first line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

LICART - PATCH, TRANSDERMAL 24 HOURS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Topical treatment of acute pain due to minor strains, sprains, and contusions.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

lidocan iii - ADHESIVE PATCH, MEDICATED

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Herpetic Neuralgia: The member must have a diagnosis of post-herpetic neuralgia. Diabetic Neuropathy: The member must have a diagnosis of diabetic neuropathy. Neuropathic cancer pain. The member has a diagnosis of neuropathic cancer pain. Chronic Back Pain: The member must have a diagnosis of chronic back pain. Pain associated with hip or knee osteoarthritis: the member must have a diagnosis of pain associated with hip or knee osteoarthritis. Brand Lidoderm request only: Members must have previous treatment with generic Lidocaine 5% patch (generic Lidoderm).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

lidocan iv - ADHESIVE PATCH, MEDICATED

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Herpetic Neuralgia: The member must have a diagnosis of post-herpetic neuralgia. Diabetic Neuropathy: The member must have a diagnosis of diabetic neuropathy. Neuropathic cancer pain. The member has a diagnosis of neuropathic cancer pain. Chronic Back Pain: The member must have a diagnosis of chronic back pain. Pain associated with hip or knee osteoarthritis: the member must have a diagnosis of pain associated with hip or knee osteoarthritis. Brand Lidoderm request only: Members must have previous treatment with generic Lidocaine 5% patch (generic Lidoderm).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

lidocan v - ADHESIVE PATCH, MEDICATED

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Herpetic Neuralgia: The member must have a diagnosis of post-herpetic neuralgia. Diabetic Neuropathy: The member must have a diagnosis of diabetic neuropathy. Neuropathic cancer pain. The member has a diagnosis of neuropathic cancer pain. Chronic Back Pain: The member must have a diagnosis of chronic back pain. Pain associated with hip or knee osteoarthritis: the member must have a diagnosis of pain associated with hip or knee osteoarthritis. Brand Lidoderm request only: Members must have previous treatment with generic Lidocaine 5% patch (generic Lidoderm).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LIDODERM - ADHESIVE PATCH, MEDICATED

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Herpetic Neuralgia: The member must have a diagnosis of post-herpetic neuralgia. Diabetic Neuropathy: The member must have a diagnosis of diabetic neuropathy. Neuropathic cancer pain. The member has a diagnosis of neuropathic cancer pain. Chronic Back Pain: The member must have a diagnosis of chronic back pain. Pain associated with hip or knee osteoarthritis: the member must have a diagnosis of pain associated with hip or knee osteoarthritis. Brand Lidoderm request only: Members must have previous treatment with generic Lidocaine 5% patch (generic Lidoderm).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LIPITOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LIQREV - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. The member has had prior therapy, contraindication, or intolerance to a phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g., sildenafil or tadalafil).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

liraglutide - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using for weight loss.
Required Medical Information	Diabetes Mellitus. The member has a diagnosis of type 2 diabetes mellitus AND Previous treatment with, contraindication to, or intolerance with TWO of the following: Mounjaro, Ozempic, Rybelsus, or Trulicity. Previous treatment requirement does not apply to liraglutide requests for pediatric members (10 to 17 years of age).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

lisdexamfetamine - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Binge Eating Disorder: The member has a diagnosis of Moderate to Severe Binge Eating Disorder (BED). ADD/ADHD: The member has a diagnosis of ADHD or ADD AND the member has had previous treatment with, contraindication, or intolerance to a long-acting stimulant (e.g. methylphenidate ER).
Age Restriction	Moderate to Severe Binge Eating Disorder (BED): 18 years of age or older. ADD/ADHD: 6 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LITFULO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Alopecia Areata: The member has a diagnosis of severe alopecia areata evidenced by at least a 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT) for more than 6 months AND the member has had previous treatment, contraindication, or intolerance to corticosteroids (e.g. betamethasone valerate lotion) or cyclosporine capsules AND the member is not using in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine, or other potent immunosuppressants.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LIVDELZI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Biliary Cholangitis: The member has a diagnosis of primary biliary cholangitis (PBC) documented by TWO of the following: Elevated serum alkaline phosphatase level for at least 6 months or Positive antimitochondrial antibody test or Liver biopsy AND The member does not have complete biliary obstruction AND The member has never had an episode of decompensated cirrhosis AND Prescribed by or in consultation with a gastroenterologist or hepatologist AND One of the following applies: The member has an intolerance to ursodiol OR The member has an inadequate response to an appropriately dosed one year trial of ursodiol defined as: Alkaline phosphatase greater than or equal to 1.67 times the upper limit of normal OR Total bilirubin greater than the upper limit of normal.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LIVMARLI - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Progressive familial intrahepatic cholestasis (PFIC): Patients with PFIC type 2 with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump (BSEP) protein AND Patients with a history of portal hypertension or a hepatic decompensation event.
Required Medical Information	Alagille Syndrome (ALGS): Member has a confirmed diagnosis of Alagille Syndrome (ALGS) with both of the following: Clinically significant cholestasis-associated pruritus as determined by the prescriber AND Elevated serum bile acids above the upper limit of normal per the lab reference normal range AND Prescribed by or in consultation with a specialist with experience treating ALGS (e.g. hepatologist, gastroenterologist) AND Has had previous treatment with or cannot use one or more of the following treatments for cholestasis-associated pruritus: ursodiol, rifampin, cholestyramine AND Does not have a history of portal hypertension or a hepatic decompensation event. Progressive Familial Intrahepatic Cholestasis (PFIC): Member has a confirmed diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) with both of the following: clinically significant cholestasis-associated pruritus as determined by the prescriber AND elevated serum bile acids above the upper limit of normal per the lab reference normal range AND prescribed by or in consultation with a specialist with experience treating PFIC (e.g. gastroenterologist, hepatologist) AND has had previous treatment with or cannot use one or more of the following treatments for cholestasis-associated pruritus: ursodiol, rifampin, cholestyramine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LIVTENCITY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must have a diagnosis of cytomegalovirus (CMV) post-transplant AND The member must be refractory to treatment with ganciclovir, valganciclovir, cidofovir or foscarnet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LOARGYS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

LODINE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LODOCO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atherosclerotic Cardiovascular Disease: The member has a diagnosis of atherosclerotic cardiovascular disease (ASCVD) OR has previously experienced a cardiovascular event AND One of the following: The member is on background lipid-lowering therapy with a maximally tolerated statin (e.g. atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR The member is statin intolerant (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms) and is receiving other lipid-lowering therapy (e.g. ezetimibe, bempedoic acid) AND The member is optimized on standard of care medications for atherosclerotic disease (e.g. aspirin, antiplatelets, anticoagulants, angiotensin-converting enzyme inhibitors/angiotensin receptor blockers, beta-blockers).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LODOSYN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

lofexidine - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Mitigation of opioid withdrawal symptoms associated with abrupt opioid discontinuation: Will be undergoing abrupt opioid discontinuation and be using Lofexidine (Lucemyra) for the mitigation of opioid withdrawal symptoms AND Has had previous treatment, contraindication, or intolerance to clonidine for mitigation of opioid withdrawal symptoms.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

Iomustine - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Gleostine (lomustine).
Required Medical Information	Brain Tumors. The member has a diagnosis of primary or metastatic brain tumor AND one of the following applies: the member will use Gleostine (lomustine) after appropriate surgical and/or radiotherapeutic procedures OR the member has recurrent or progressive disease. Hodgkin Lymphoma. The member has a diagnosis of Hodgkin Lymphoma AND the member has disease progression following initial chemotherapy AND the member will use Gleostine (lomustine) as a component of combination chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LONSURF - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Lonsurf.
Required Medical Information	Metastatic Colorectal Cancer: The member has a diagnosis of metastatic colorectal cancer AND The member is using Lonsurf as monotherapy or in combination with bevacizumab product AND The member has experienced disease progression, intolerance, or contraindication with the following therapies: fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine), oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, and if appropriate, an anti-VEGF therapy (e.g., bevacizumab product) AND If the member is RAS wild-type: the member has experienced disease progression, intolerance, or contraindication with anti-EGFR therapy (e.g. cetuximab or panitumumab). Gastric cancer. The member has recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma AND The member has experienced disease progression on or after two lines of therapy including fluoropyrimidine (e.g., 5-fluorouracil), platinum (e.g., cisplatin), either taxane (e.g., paclitaxel) or irinotecan and if appropriate, HER2/neu-targeted therapy (e.g., trastuzumab) AND Lonsurf will be given subsequent therapy as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	
Part B Prerequisite	0

LOPID - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LOPROX (AS OLAMINE) - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LOQTORZI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on or after prior PD-1/PD-L1 inhibitor (e.g., Keytruda).
Required Medical Information	Nasopharyngeal carcinoma (NPC): The member has a diagnosis of metastatic or recurrent, locally advanced NPC AND One of the following applies: Loqtorzi (toripalimab-tpzi) will be used in first-line setting in combination with cisplatin and gemcitabine, followed by monotherapy OR Loqtorzi (toripalimab-tpzi) will be used as a single agent for disease progression on or after a platinum-containing regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

LORBRENA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer. The member has a diagnosis of metastatic NSCLC with documented anaplastic lymphoma kinase (ALK) positivity AND Lorbrena (lorlatinib) will be given as monotherapy AND one of the following applies in the metastatic setting: as first line therapy AND the member has a medical reason as to why Alecensa (alectinib) or Alunbrig (brigatinib) cannot be initiated or continued as first line therapy OR Subsequent therapy after disease progression on prior ALK inhibitor (e.g., alectinib, brigatinib). Non- small cell lung cancer [ROS-1 rearrangement]: The member has a diagnosis of recurrent, advanced, or metastatic non-small cell lung cancer AND The disease is positive for documented ROS-1 rearrangement and following disease progression on Xalkori (crizotinib), Rozlytrek (entrectinib), or Zykadia (ceritinib) AND Lorbrena (lorlatinib) will be given as a single agent as subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LOREEV XR - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Anxiety Disorder: The member is an adult with a clinical diagnosis of anxiety disorder as defined by DSM-5 criteria and/or appropriate anxiety rating scale (e.g. GAD-7) AND The member must have had previous treatment, contraindication, or intolerance to at least one of the following: an SSRI (e.g. escitalopram), SNRI (e.g. venlafaxine), or buspirone AND The member must have had previous treatment with generic lorazepam tablets AND The member must currently be receiving stable, evenly divided, three times daily dosing with generic lorazepam tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

LOTREL - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LOTRONEX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of severe diarrhea-predominant irritable bowel syndrome, AND The member has chronic IBS symptoms (lasting 6 months or longer), AND The member has had previous treatment with, contraindication, or intolerance to at least two of the following: loperamide, a tricyclic antidepressant (e.g. amitriptyline, nortriptyline, imipramine HCl, desipramine), or Xifaxan.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LOVAZA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LOVENOX - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LUCEMYRA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Mitigation of opioid withdrawal symptoms associated with abrupt opioid discontinuation: Will be undergoing abrupt opioid discontinuation and be using Lofexidine (Lucemyra) for the mitigation of opioid withdrawal symptoms AND Has had previous treatment, contraindication, or intolerance to clonidine for mitigation of opioid withdrawal symptoms.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LUMAKRAS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on a KRAS G12C inhibitor (e.g., sotorasib, adagrasib). [All indications]
Required Medical Information	Non-small cell lung cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic NSCLC AND The NSCLC has documented KRAS G12C mutation AND The member has experienced disease progression on one prior therapy AND Lumakras (sotorasib) will be given as monotherapy as subsequent treatment. Colorectal Cancer [KRAS G12C-mutated]: The member has a diagnosis of metastatic colorectal cancer (mCRC) AND The disease is documented as KRAS G12C-mutated, as determined by an FDA-approved test AND The member has received prior systemic treatment with chemotherapy [fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine), oxaliplatin, irinotecan] AND Lumakras (sotorasib) will be given in combination with Vectibix (panitumumab).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

LUMIZYME - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Alglucosidase alpha (Lumizyme) will require prior authorization. These agents may be considered medically necessary when the following criteria are met: Members must have a diagnosis of Pompe disease.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year
Other Criteria	NA
Part B Prerequisite	0

LUMRYZ - PACKET, EXTENDED RELEASE GRANULES

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Narcolepsy with cataplexy: The member must have a diagnosis of narcolepsy with cataplexy. Narcolepsy with excessive daytime sleepiness: The member has a diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria AND The member has condition of excessive daytime sleepiness (EDS) associated with narcolepsy as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND Previous treatment, contraindication, or intolerance with: at least one CNS stimulant (e.g., methylphenidate or amphetamine salt combination immediate release) and modafinil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	The member will be using no more than one of the following products at any given time: Lumryz (sodium oxybate), Xyrem (sodium oxybate), Xywav (calcium magnesium, potassium, and sodium oxybates), Wakix (pitolisant), or Sunosi (solriamfetol).
Part B Prerequisite	0

LUMRYZ STARTER PACK - GRANULES EXT RELEASE IN PACKET,DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Narcolepsy with cataplexy: The member must have a diagnosis of narcolepsy with cataplexy. Narcolepsy with excessive daytime sleepiness: The member has a diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria AND The member has condition of excessive daytime sleepiness (EDS) associated with narcolepsy as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND Previous treatment, contraindication, or intolerance with: at least one CNS stimulant (e.g., methylphenidate or amphetamine salt combination immediate release) and modafinil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	The member will be using no more than one of the following products at any given time: Lumryz (sodium oxybate), Xyrem (sodium oxybate), Xywav (calcium magnesium, potassium, and sodium oxybates), Wakix (pitolisant), or Sunosi (solriamfetol).
Part B Prerequisite	0

LUNESTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LUNSUMIO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following Lunsumio (mosunetuzumab-axgb) or Lunsumio Velo (mosunetuzumab-axgb).
Required Medical Information	Follicular Lymphoma. The member has a diagnosis of follicular lymphoma AND the member has relapsed or refractory disease AND the member has received at least two prior lines of systemic therapy AND the member will be using Lunsumio (mosunetuzumab-axgb) or Lunsumio Velo (mosunetuzumab-axgb) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

LUNSUMIO VELO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following Lunsumio (mosunetuzumab-axgb) or Lunsumio Velo (mosunetuzumab-axgb).
Required Medical Information	Follicular Lymphoma. The member has a diagnosis of follicular lymphoma AND the member has relapsed or refractory disease AND the member has received at least two prior lines of systemic therapy AND the member will be using Lunsumio (mosunetuzumab-axgb) or Lunsumio Velo (mosunetuzumab-axgb) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

LUPKYNIS - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Lupus Nephritis: Member has a diagnosis of biopsy proven class III, IV, or V lupus nephritis AND the member will use Lupkynis in combination with a background immunosuppressive therapy regimen (e.g. corticosteroids and mycophenolate mofetil) AND will not use Lupkynis in combination with cyclophosphamide AND the member is prescribed Lupkynis by or in consultation with a provider who has expertise in treating active lupus nephritis (i.e. rheumatologist or nephrologist).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LUPRON DEPOT - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomyoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer: The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer AND The patient must be pre or perimenopausal. Recurrent Ovarian Cancer: Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	
Part B Prerequisite	0

LUPRON DEPOT (3 MONTH) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomyoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer: The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer AND The patient must be pre or perimenopausal. Recurrent Ovarian Cancer: Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	
Part B Prerequisite	0

LUPRON DEPOT (4 MONTH) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomyoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer: The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer AND The patient must be pre or perimenopausal. Recurrent Ovarian Cancer: Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	
Part B Prerequisite	0

LUPRON DEPOT (6 MONTH) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomyoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer: The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer AND The patient must be pre or perimenopausal. Recurrent Ovarian Cancer: Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	
Part B Prerequisite	0

LUPRON DEPOT-PED - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomyoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer: The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer AND The patient must be pre or perimenopausal. Recurrent Ovarian Cancer: Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	
Part B Prerequisite	0

LUPRON DEPOT-PED (3 MONTH) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomyoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer: The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer AND The patient must be pre or perimenopausal. Recurrent Ovarian Cancer: Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	
Part B Prerequisite	0

LUTRATE DEPOT (3 MONTH) - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomyoma. Central Precocious Puberty: Pediatric member with a diagnosis of central precocious puberty (idiopathic or neurogenic). Invasive Breast Cancer: The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer AND The patient must be pre or perimenopausal. Recurrent Ovarian Cancer: Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration for all except for Endometriosis: 6 months and Uterine Leiomyoma: 3 months
Other Criteria	
Part B Prerequisite	0

LYBALVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use of opioids. Episode of acute opioid withdrawal.
Required Medical Information	Schizophrenia: The member must have a diagnosis of schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to at least one of the following generic atypical antipsychotics: olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (acute manic or mixed, maintenance monotherapy): The member must have a diagnosis of bipolar I disorder (acute manic or mixed, maintenance monotherapy) AND The member must have documentation of prior therapy, intolerance, or contraindication to at least one of the following generic atypical antipsychotics: olanzapine, risperidone, quetiapine, ziprasidone, or aripiprazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LYNKUET - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Vasomotor Symptoms Associated with Menopause: Has a diagnosis of moderate to severe vasomotor symptoms associated with menopause AND Has tried or cannot use one of the following: a menopausal hormone therapy (e.g. estradiol tablet/patch, estradiol-norethindrone acetate tablets) OR an SSRI (selective serotonin reuptake inhibitor) or SNRI (serotonin and norepinephrine reuptake inhibitor) (e.g. citalopram, fluoxetine, paroxetine, venlafaxine, or desvenlafaxine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LYNOZYFIC - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on a bispecific B-cell maturation antigen (BCMA)-directed CD3 T-cell engager-containing regimen.
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member has relapsed/refractory disease AND The member has received at least four prior lines of therapy including a proteasome inhibitor (e.g. bortezomib), an immunomodulatory agent (e.g. lenalidomide), and an anti-CD38 monoclonal antibody (e.g. daratumumab) AND The member is using Lynozyfic (linvoseltamab-gcpt) as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

LYNPARZA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g. Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)]. Adjuvant setting for High-Risk Early Breast Cancer: member is taking Lynparza (olaparib) total treatment for more than one year.
Required Medical Information	Breast Cancer (Metastatic): Member has a diagnosis of recurrent or metastatic breast cancer AND Member has deleterious germline or suspected germline BRCA-mutated disease as detected by an FDA-approved test AND Member has HER-2 negative disease, hormone receptor positive or negative, treated with prior chemotherapy and/or endocrine therapy AND Lynparza will be used as subsequent therapy as a single agent. Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer First Line Maintenance Therapy: The member has a diagnosis of advanced epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND member's disease is associated with homologous recombination deficiency (HRD) positive status defined by either: a deleterious or suspected deleterious BRCA mutation or genomic instability as defined by and FDA approved test. Member is in complete response or partial response to first line treatment with platinum based chemotherapy. Epithelial Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer Subsequent Line Maintenance Therapy: The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Lynparza (olaparib) tablets as monotherapy. *Discontinue Bevacizumab Product before initiating maintenance therapy with Lynparza.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

LYNPARZA - TABLET

Other Criteria	Pancreatic Adenocarcinoma - First line maintenance therapy: Member has a diagnosis of metastatic pancreatic adenocarcinoma AND member has deleterious germline or suspected germline BRCA-mutated disease AND member's disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen. Metastatic Castration-Resistant Prostate Cancer (mCRPC): Member has a diagnosis metastatic castration-resistant prostate cancer (mCRPC) AND Member will use Lynparza (olaparib) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]) AND the member has one of the following: Member has documented deleterious or suspected deleterious germline, or somatic homologous recombination repair (HRR) gene-mutated disease AND Member has experienced progressive disease following prior treatment with Xtandi (enzalutamide) or abiraterone OR Member has deleterious germline or suspected germline BRCA-mutated (BRCAm) disease AND Member will use in combination with abiraterone and prednisone or prednisolone. Breast Cancer (Adjuvant): Member has a diagnosis of high-risk early breast cancer AND Member has deleterious germline or suspected germline BRCA-mutated disease as detected by an FDA-approved test AND Member has HER-2 negative disease, hormone receptor positive or negative, treated with prior chemotherapy AND Lynparza will be used as subsequent therapy as a single agent. High Risk early breast cancer defined as patients who: 1. Received prior neoadjuvant chemotherapy: patients with either triple negative breast cancer (TNBC) or hormone receptor positive breast cancer must have had residual invasive cancer in the breast and/or the resected lymph nodes (nonpathologic complete response) at the time of surgery. Additionally, patients with hormone receptor positive breast cancer must have had a score of greater than or equal to 3 based on pretreatment clinical and post-treatment pathologic stage (CPS), estrogen receptor (ER) status, and histologic grade. 2. TNBC with greater than or equal to pT2 or greater than or equal to pN1 prior to adjuvant chemotherapy 3. HR+/HER2-negative with greater than or equal to 4 positive lymph nodes prior to adjuvant chemotherapy.
Part B Prerequisite	0

LYRICA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LYRICA CR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neuropathic pain associated with diabetic peripheral neuropathy (DPN). The member must have a diagnosis of diabetic peripheral neuropathy. The member has had previous treatment with at least two of the following: gabapentin, duloxetine, lidocaine 5% topical patch, pregabalin (immediate release). Post-Herpetic Neuralgia (PHN). The member must have a diagnosis of post-herpetic neuralgia. The member has had previous treatment with at least two of the following: gabapentin, lidocaine 5% topical patch, pregabalin (immediate release).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

LYTGOBI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression on Lytgobi (futibatinib)
Required Medical Information	Cholangiocarcinoma: The member has unresectable locally advanced or metastatic intrahepatic cholangiocarcinoma (iCCA) AND The member has iCCA with documented FGFR2 gene fusions or other rearrangements AND The member has received prior treatment AND Lytgobi (futibatinib) is given as a single agent for subsequent therapy
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

MALARONE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MALARONE PEDIATRIC - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MARGENZA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Margenza (margetuximab-cmkb).
Required Medical Information	Breast cancer: The member has a diagnosis of metastatic breast cancer AND The disease is documented HER2 neu positive AND The member has received two prior anti-HER2 neu based therapies (including trastuzumab products) where one therapy was given in the metastatic setting AND Margenza (margetuximab-cmkb) is given in combination with chemotherapy (gemcitabine, eribulin, vinorelbine, capecitabine) as subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MAVENCLAD (10 TABLET PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	More than 2 treatment courses within a 2 year period.
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease AND All of the following have been ruled out before starting Mavenclad (cladribine): current malignancy, human immunodeficiency virus (HIV) infection, active hepatitis, active tuberculosis AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAVENCLAD (4 TABLET PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	More than 2 treatment courses within a 2 year period.
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease AND All of the following have been ruled out before starting Mavenclad (cladribine): current malignancy, human immunodeficiency virus (HIV) infection, active hepatitis, active tuberculosis AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAVENCLAD (5 TABLET PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	More than 2 treatment courses within a 2 year period.
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease AND All of the following have been ruled out before starting Mavenclad (cladribine): current malignancy, human immunodeficiency virus (HIV) infection, active hepatitis, active tuberculosis AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAVENCLAD (6 TABLET PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	More than 2 treatment courses within a 2 year period.
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease AND All of the following have been ruled out before starting Mavenclad (cladribine): current malignancy, human immunodeficiency virus (HIV) infection, active hepatitis, active tuberculosis AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAVENCLAD (7 TABLET PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	More than 2 treatment courses within a 2 year period.
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease AND All of the following have been ruled out before starting Mavenclad (cladribine): current malignancy, human immunodeficiency virus (HIV) infection, active hepatitis, active tuberculosis AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAVENCLAD (8 TABLET PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	More than 2 treatment courses within a 2 year period.
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease AND All of the following have been ruled out before starting Mavenclad (cladribine): current malignancy, human immunodeficiency virus (HIV) infection, active hepatitis, active tuberculosis AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAVENCLAD (9 TABLET PACK) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	More than 2 treatment courses within a 2 year period.
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease AND All of the following have been ruled out before starting Mavenclad (cladribine): current malignancy, human immunodeficiency virus (HIV) infection, active hepatitis, active tuberculosis AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAVYRET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant therapy with atazanavir, rifampin, efavirenz, carbamazepine, lopinavir, ritonavir, or darunavir. Child-Pugh Class B or C cirrhosis.
Required Medical Information	Treatment of Acute or Chronic Hepatitis C - Adults. The member must have a diagnosis of acute or chronic hepatitis C (HCV). Member must be non-cirrhotic OR have compensated cirrhosis (Child-Pugh Class A). Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa.
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	8 to 16 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	Post-Liver Transplant - Member must have received a liver transplant. Member must have experienced recurrent HCV infection post-transplant in the allograft liver. Member must be non-cirrhotic OR have compensated cirrhosis (Child-Pugh Class A). Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. Acute or Chronic Hepatitis C - Pediatrics: Member must have a diagnosis of acute or chronic hepatitis C infection. Member must be non-cirrhotic OR have compensated cirrhosis (Child-Pugh Class A). Member must have failed to achieve SVR after completing a full course of Epclusa.
Part B Prerequisite	0

MAXALT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAXALT-MLT - TABLET,DISINTEGRATING

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAXZIDE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAYZENT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAYZENT STARTER(FOR 1MG MAINT) - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MAYZENT STARTER(FOR 2MG MAINT) - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MEKINIST - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Melanoma - Unresectable or metastatic: Members on concomitant Yervoy (ipilimumab), Zelboraf (vemurafenib), Opdivo (nivolumab), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Mekinist (trametinib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)]. Non-small cell lung cancer, Anaplastic Thyroid Cancer and Metastatic Solid Tumors: Members on concomitant Yervoy (ipilimumab), Zelboraf (vemurafenib), Opdivo (nivolumab), Keytruda (pembrolizumab), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)]. Adjuvant melanoma: member is taking Mekinist (trametinib) total treatment for more than one year. Members on concomitant Yervoy (ipilimumab), Zelboraf (vemurafenib), Opdivo (nivolumab), Keytruda (pembrolizumab), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)]. Low-grade Glioma: Members that have experienced disease progression while on Mekinist (trametinib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)].

MEKINIST - TABLET

Required Medical Information	Melanoma - Unresectable or Metastatic: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Mekinist as a single-agent (member has not received prior BRAF-inhibitor therapy) OR in combination with Tafenlar (dabrafenib). Non-small cell lung cancer: The member has a diagnosis of recurrent or metastatic non-small cell lung cancer(NSCLC) AND The member has a documented BRAF V600E mutation AND The member will be using Mekinist (trametinib) in combination with Tafenlar (dabrafenib). Melanoma - Adjuvant. The member has a diagnosis of stage III melanoma AND The member has undergone lymph node resection of involved lymph nodes AND The member has a documented BRAF V600 activating mutation AND The member will be using Mekinist (trametinib) in combination with Tafenlar (dabrafenib) for adjuvant treatment. Anaplastic Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer AND The member has a documented V600E mutation AND The member has no satisfactory locoregional treatment options AND The member will be using Tafenlar (dabrafenib) in combination with Mekinist (trametinib). Metastatic Solid Tumors: the member has a diagnosis of unresectable or metastatic solid tumors with documented BRAF V600E mutation AND the member has disease that has progressed on prior therapy and has no satisfactory alternative treatments AND Mekinist is given in combination with Tafenlar. Low-grade Glioma: The member has a diagnosis of low-grade glioma (LGG) AND The member has a documented BRAF V600E mutation AND Mekinist (trametinib) will be used in combination with Tafenlar (dabrafenib).
Age Restriction	Low-grade Glioma only: The member is a pediatric age 1 year of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MEKTOVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic (cobimetinib), Tafinlar (dabrafenib), or Mekinist (trametinib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Tafinlar (dabrafenib) with Mekinist (trametinib)].
Required Medical Information	Melanoma - Unresectable or metastatic. The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib). Metastatic non-small cell lung cancer: The member has documented BRAF V600E metastatic non-small cell lung cancer (NSCLC) AND The member will be using Braftovi (encorafenib) in combination with Mektovi (binimetinib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

memantine - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Diagnosis of Autism or Atypical Autism (PDD)
Required Medical Information	
Age Restriction	An automatic approval if member is greater than 26 years of age.Prior Auth required for age 26 or younger.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

memantine-donepezil - CAPSULE SPRINKLE, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of moderate to severe Alzheimer's dementia AND The member cannot use memantine (Namenda) and donepezil (Aricept).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MEPSEVII - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Mucopolysaccharidosis VII (MPS VII, Sly Syndrome): The member has a diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly Syndrome).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA
Part B Prerequisite	0

MESTINON - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MESTINON TIMESPAN - TABLET, EXTENDED RELEASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

methocarbamol - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Musculoskeletal Pain: member is using this product as adjunct to rest, physical therapy, and other measures for relief of musculoskeletal pain associated with acute, painful musculoskeletal conditions AND has had a trial with, intolerance, or contraindication to methocarbamol 500 mg tablets AND 750 mg tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

METHYLIN - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

METROCREAM - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

METROLOTION - LOTION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MICARDIS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MICARDIS HCT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MIEBO (PF) - DROPS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dry eye disease. Has a diagnosis of dry eye disease AND has had previous treatment, contraindication, or intolerance to the following: cyclosporine eye drops (generic Restasis), AND Eysuvis (loteprednol)*. *Previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

mifepristone - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hyperglycemia secondary to hypercortisolism. Diagnosis of endogenous Cushing's syndrome. AND Type 2 diabetes mellitus or glucose intolerance. AND Failed surgery or are not candidates for surgery.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

miglustat - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 1 Gaucher Disease. The member must have a diagnosis of type 1 Gaucher's Disease AND the member has had prior therapy, contraindication, or intolerance to Elvelyo (taliglucerase).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

milnacipran - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Fibromyalgia: Has a diagnosis of fibromyalgia, and has had previous treatment, contraindication, or intolerance to at least TWO of the following: pregabalin, duloxetine, gabapentin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MINOCIN - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MIPLYFFA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Niemann-Pick disease type C (NPC): Member has a diagnosis of Niemann-Pick disease type C (NPC) AND Provider attests that the diagnosis of NPC has been confirmed by one of the following: Genetically confirmed by mutations in both alleles of NPC1 or NPC2 OR Mutation in one allele of NPC1 or NPC2 AND either positive filipin staining OR elevated cholestane triol/oxysterols (greater than 2 times the upper limit of normal) AND Miplyffa will be used in combination with miglustat AND Member has at least one neurological symptom of Niemann Pick disease type C (NPC) (e.g., hearing loss, difficulty swallowing, fine motor skill loss, difficulty walking).
Age Restriction	
Prescriber Restriction	Miplyffa is prescribed by or in consultation with a provider with expertise in the treatment of Niemann-Pick disease type C.
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MIRCERA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Anemia of Chronic Kidney Disease: Initial Therapy: The member must have a diagnosis of anemia associated with chronic kidney disease (i.e., chronic renal failure or equivalent). The member must have a hemoglobin (Hgb) level less than 10 g/dL or hematocrit (HCT) less than 30 (within the last four weeks). Prior to initiation of therapy, the member's iron stores should be evaluated. Transferrin saturation should be at least 20% or ferritin at least 100 ng/mL within the last 4 weeks (applies to most recent result). Other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Continuing Therapy: The member must meet the following criteria: Documented Transferrin saturation of at least 20% or ferritin of at least 100 ng/mL within the last 4 months (applies to most recent result). AND Current (within the last four weeks) hemoglobin (Hgb) level less than 11 g/dL OR documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial auth approved for 6 months. Reauth approved for plan year duration.
Other Criteria	NA
Part B Prerequisite	0

MITIGARE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of gout flares. The member has a diagnosis of gout AND The member will be using colchicine products for the prophylaxis of gout flares AND The member will be using concomitant or has a contraindication to urate lowering therapy AND The member has had previous treatment failure with colchicine tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MODD1 PATIENT WELCOME KIT - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member requires basal insulin rates greater than 4 U/hr or less than 0.5U/hr.
Required Medical Information	Diabetes Mellitus: The member has a confirmed diagnosis of diabetes mellitus requiring insulin therapy AND The member must meet at least one of the following: Inadequate glycemic control despite adherence to multiple daily injections (MDI), lifestyle modifications, and standard diabetes management strategies OR History of clinically significant glycemic variability, recurrent hypoglycemia, or hyperglycemia requiring intensive insulin therapy OR Need for frequent insulin dosing adjustments or documentation of insulin-treated diabetes requiring greater than or equal to 3 insulin injections per day. The member is willing and able to perform adequate glucose monitoring, including a minimum of four blood glucose checks per day (if clinically required).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MODD1 SUPPLY KIT - COMBINATION PACKAGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member requires basal insulin rates greater than 4 U/hr or less than 0.5U/hr.
Required Medical Information	Diabetes Mellitus: The member has a confirmed diagnosis of diabetes mellitus requiring insulin therapy AND The member must meet at least one of the following: Inadequate glycemic control despite adherence to multiple daily injections (MDI), lifestyle modifications, and standard diabetes management strategies OR History of clinically significant glycemic variability, recurrent hypoglycemia, or hyperglycemia requiring intensive insulin therapy OR Need for frequent insulin dosing adjustments or documentation of insulin-treated diabetes requiring greater than or equal to 3 insulin injections per day. The member is willing and able to perform adequate glucose monitoring, including a minimum of four blood glucose checks per day (if clinically required).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MODEYSO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diffuse Midline Glioma: The member has a diagnosis of diffuse midline glioma AND The disease has documented H3 K27M mutation AND The member has experienced disease progression or recurrence following prior therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MONJUVI - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Diffuse large B-cell lymphoma: The member has experienced disease progression on anti-CD-19-directed therapy. Follicular lymphoma: Total treatment duration with Monjuvi (tafasitamab-cxix) is more than 12 cycles.
Required Medical Information	Diffuse large B-cell lymphoma: The member has a diagnosis of diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma (e.g. follicular lymphoma) AND The member has relapsed or refractory disease AND The member is not eligible for autologous stem cell transplant AND The member will be using Monjuvi (tafasitamab-cxix) in combination with lenalidomide for a maximum of 12 cycles, then Monjuvi (tafasitamab-cxix) can be used as a single agent. Follicular lymphoma: The member has a diagnosis of follicular lymphoma AND The member has relapsed or refractory disease AND The member will be using Monjuvi (tafasitamab-cxix) in combination with lenalidomide and a rituximab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MOTTEGRITY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Idiopathic Constipation: The member must have a diagnosis of chronic idiopathic constipation AND the member has had previous treatment, intolerance, or contraindication to Linzess (linaclotide) and lubiprostone.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MOTPOLY XR - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: The member has a diagnosis of partial-onset (focal) seizures AND The member weighs at least 50 kg (approximately 110 pounds) AND The member has been unable to achieve seizure control with generic lacosamide AND at least one other drug for controlling partial-onset seizures (e.g. levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate). Adjunctive treatment of generalized tonic-clonic seizures: The member has a diagnosis of generalized tonic-clonic seizures AND the member weighs at least 50 kg (approximately 110 pounds) AND the member will use Motpoly XR (lacosamide extended-release) in combination with at least one other drug for controlling seizures AND the member has been unable to achieve seizure control with generic lacosamide AND at least one other drug for controlling generalized tonic-clonic seizures (e.g., lamotrigine, topiramate, carbamazepine, gabapentin, divalproex).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MOUNJARO - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using for weight loss.
Required Medical Information	Diabetes Mellitus. The member has a diagnosis of type 2 diabetes mellitus.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

MOZOBIL - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use beyond four consecutive days or use after completion of stem cell harvest/apheresis.
Required Medical Information	Autologous transplantation in patients with non-Hodgkin's Lymphoma (NHL) or Multiple Myeloma (MM): The member must have a diagnosis of non-Hodgkin's Lymphoma (NHL) or multiple myeloma (MM) AND Mozobil (plerixafor) must be used in combination with any GCSF (e.g., filgrastim, pegfilgrastim) or GM-CSF (e.g., sargramostim) AND Mozobil (plerixafor) must be a component of an autologous stem cell transplant mobilization protocol.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

MS CONTIN - TABLET, EXTENDED RELEASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MULPLETA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Treatment of Thrombocytopenia: Member has a diagnosis of chronic liver disease (CLD) AND Member is scheduled to undergo a procedure and would otherwise require a platelet transfusion AND Mulpleta will be initiated 8-14 days prior to a scheduled procedure.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 Months Duration
Other Criteria	
Part B Prerequisite	0

MVASI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Malignant Pleural Mesothelioma, Soft Tissue Sarcoma, Recurrent Primary CNS Tumor (including Glioblastoma multiforme), Renal Cell Carcinoma, Non-small cell lung cancer (non-squamous cell histology): The member has experienced disease progression while on or following a bevacizumab product. Metastatic colorectal cancer: A bevacizumab product may not be used in conjunction with Vectibix (panitumumab) or Erbitux (cetuximab).
Required Medical Information	For Avastin (bevacizumab), Alymsys (bevacizumab-maly), Jobevne (bevacizumab-nwgd), and Vegzelma (bevacizumab-adcd) oncology requests: member must have an intolerance or contraindication with Mvasi or Zirabev. Metastatic colorectal cancer: metastatic colorectal cancer AND 1 of the following applies: using a bevacizumab product in combo with fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemo for 1st or 2nd-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemo for 2nd-line therapy in patients who have progressed on 1st-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). NSCLC with non-squamous cell histology AND the disease is unresectable, locally advanced, recurrent, or metastatic AND A bevacizumab product will be used as part of a supported combination chemotherapy. Hepatocellular carcinoma: unresectable or metastatic HCC AND a bevacizumab product will be used as 1st line therapy in combo with an atezolizumab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

MVASI - VIAL (ML)

Other Criteria	Renal cell carcinoma: Member has RCC and a bevacizumab product will be used in combo with interferon alpha. Recurrent Primary CNS Tumor (including Glioblastoma multiforme): Diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND a bevacizumab product is being used as a single agent or in combo with irinotecan, carmustine, lomustine or temozolomide AND the member does not have a CNS hemorrhage. Soft Tissue Sarcoma: One of the following applies: Diagnosis of angiosarcoma AND a bevacizumab product is being used as a single agent OR The member has a diagnosis of solitary fibrous tumor and a bevacizumab product is being used in combo with temozolomide. Macular Retinal Edema. Avastin is being used to treat central or branch retinal vein occlusion with macular retinal edema. Cervical Cancer: member has recurrent, or metastatic cervical cancer AND A bevacizumab product will be used as part of a supported combination therapy. Endometrial Cancer: The member has a diagnosis of endometrial cancer AND One of the following applies: The member has stage III-IV disease or recurrent disease AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, followed by maintenance with a bevacizumab product maintenance OR The member has recurrent disease AND a bevacizumab product monotherapy will be used as second-line or subsequent therapy if not previously used. Malignant Pleural Mesothelioma. Diagnosis of unresectable malignant pleural mesothelioma and a bevacizumab product will be used in combo with cisplatin and pemetrexed or carboplatin and pemetrexed followed by maintenance with a bevacizumab product (for responders). Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer AND One of the following applies: The disease is recurrent, platinum-resistant AND a bevacizumab product will be used in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan AND the member has not received more than 2 prior chemotherapy regimens OR The disease is recurrent, platinum-sensitive AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, or in combination with carboplatin and gemcitabine, followed by a bevacizumab product monotherapy AND The disease is stage III or IV AND initial surgical resection was completed AND a bevacizumab product will be used in combo with carboplatin and paclitaxel, followed by a bevacizumab product monotherapy OR . Age Related Macular Degeneration (Avastin requests only): Avastin (bevacizumab) is being used to treat age related macular degeneration. Diabetic Macular Edema (Avastin requests only): Avastin (bevacizumab) is being used to treat diabetic macular edema.
Part B Prerequisite	0

MYALEPT - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Partial lipodystrophy OR Liver disease including non-alcoholic steatohepatitis (NASH) OR HIV related lipodystrophy OR Diabetes mellitus and hypertriglyceridemia without concurrent evidence of congenital or acquired generalized lipodystrophy OR Generalized obesity not associated with congenital leptin deficiency.
Required Medical Information	Congenital of Acquired Lipodystrophy: The member has a diagnosis of congenital OR acquired generalized lipodystrophy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA
Part B Prerequisite	0

MYCAPSSA - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Acromegaly: The member has a diagnosis of Acromegaly AND The member is currently established on baseline octreotide or lanreotide AND The member has responded to therapy with octreotide or lanreotide (e.g. IGF-1 levels are within normal limits) AND The member has tolerated therapy with octreotide or lanreotide.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

MYFEMBREE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Known osteoporosis. Greater than 24 months of therapy will not be permitted based on dosing information on label.
Required Medical Information	Heavy Menstrual Bleeding Associated with Uterine Leiomyomas: The member must be premenopausal AND The member must have a diagnosis of uterine leiomyomas (fibroids) AND The member must be experiencing heavy menstrual bleeding associated with uterine fibroids AND The member has had previous treatment, contraindication, or intolerance with tranexamic acid tablet . Moderate to severe pain associated with endometriosis (Myfembree only): the member must have a diagnosis of endometriosis AND the member must have moderate to severe pain associated with endometriosis AND the member must be premenopausal AND the member has had previous treatment, contraindication, or intolerance with a hormone contraceptive (e.g. drospirenone-ethinyl estradiol, norethindrone acetate-ethinyl estradiol) or nonsteroidal anti-inflammatory (e.g. naproxen, ibuprofen).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

MYLOTARG - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member has experienced disease progression on Mylotarg (gemtuzumab ozogamicin)
Required Medical Information	Acute Myelogenous Leukemia: The member has a diagnosis of acute myeloid leukemia (AML) AND the member has documented CD33-positive disease AND One of the following applies: the member has newly-diagnosed disease and is an adult or pediatric patient one month or older OR the member has relapsed/refractory disease and is an adult or pediatric patient 2 years and older.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Newly dx AML:6 months(max 1 cycle induction-8 cycles consolidation) Rel/Ref AML:3months(max 1 cycle)
Other Criteria	NA
Part B Prerequisite	0

MYQORZO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Obstructive Hypertrophic Cardiomyopathy (Initial): The member must have a diagnosis of hypertrophic cardiomyopathy AND The member must have confirmation of an obstruction (e.g. cardiac MRI, echocardiogram, or cardiac catheterization) AND The member must have NYHA Class II-III symptoms AND The member must have a left ventricular ejection fraction (LVEF) greater than 55% AND The member has had previous treatment, intolerance, or contraindication to beta-blockers (e.g. atenolol, metoprolol, bisoprolol) or non-dihydropyridine calcium channel blockers (e.g. verapamil, diltiazem) at doses appropriate for obstructive hypertrophic cardiomyopathy. Obstructive Hypertrophic Cardiomyopathy (Reauth): The member must have a LVEF greater than 40% AND The member has had clinically significant improvement of symptoms (e.g. improvement in NT-proBNP, decreased shortness of breath, improvement in patient reported outcomes assessment) AND Provider attestation that the patient has not and will not receive septal reduction therapy (SRT) while on aficamten therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: 6 months duration. Reauth: Plan year duration.
Other Criteria	
Part B Prerequisite	0

MYSOLINE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

MYTESI - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Relief of non-infectious diarrhea in adult patients with HIV/AIDS on anti-retroviral therapy: The member has a diagnosis of HIV infection or AIDS AND The member is currently receiving antiretroviral therapy AND The member has non-infectious diarrhea AND The member has a trial, intolerance, or contraindication to loperamide or diphenoxylate/atropine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year duration
Other Criteria	
Part B Prerequisite	0

NAGLAZYME - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome).The member must have a diagnosis of mucopolysaccharidosis VI (MPS VI,Maroteaux-Lamy syndrome).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year
Other Criteria	NA
Part B Prerequisite	0

nalocet - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Pain: Has pain severe enough to require an opioid pain medication and for which alternative treatments are inadequate AND Has had previous treatment, contraindication, or intolerance to BOTH of the following: hydrocodone-325mg acetaminophen tablet (e.g., generic Norco) AND oxycodone-325mg acetaminophen tablet (e.g., generic Percocet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NAMENDA XR - CAPSULE SPRINKLE, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NAMZARIC - CAPSULE SPRINKLE, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of moderate to severe Alzheimer's dementia AND The member cannot use memantine (Namenda) and donepezil (Aricept).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NAPROSYN - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

naproxen-esomeprazole - TABLET,IMMEDIATE,DELAY RELEASE,BIPHASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, or juvenile idiopathic arthritis (JIA): The member will be using Vimovo for the relief of signs and symptoms of rheumatoid arthritis, osteoarthritis, or ankylosing spondylitis, or for juvenile idiopathic arthritis (JIA) in adolescent members AND member has had prior treatment with two combinations of a prescription strength NSAID taken with proton pump inhibitor (PPI).
Age Restriction	Member is 12 years of age and older and weighs at least 38 kg (83 pounds).
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NARCAN - SPRAY, NON-AEROSOL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NEFFY - SPRAY, NON-AEROSOL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Emergency Treatment of Allergic Reactions: Requested product will be used for emergency treatment of an allergic reaction (Type I) including anaphylaxis AND Has had previous treatment or intolerance with one of the following: epinephrine auto-injector (generic Epipen) or Auvi-Q auto-injector.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NEMLUVIO - PEN INJECTOR (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prurigo Nodularis: The member has a diagnosis of prurigo nodularis AND Prescribed by or in consultation with a dermatologist, allergist, or immunologist AND The member has had previous treatment with, intolerance, or contraindication to Dupixent. Atopic Dermatitis: The member has a diagnosis of moderate to severe atopic dermatitis (e.g. erythema, moderate to severe induration/papulation, frequent or incessant itching, frequent nightly loss of sleep) AND The member has had an inadequate response to one high potency topical corticosteroid (e.g. augmented betamethasone dipropionate 0.05%, clobetasol cream/ointment, triamcinolone acetonide 0.5%) or one topical calcineurin inhibitor (e.g. tacrolimus ointment) AND The member has had previous treatment with, intolerance, or contraindication to Dupixent AND Nemluvio will be used in combination with a topical corticosteroid and/or a topical calcineurin inhibitor.
Age Restriction	Prurigo Nodularis: The member must be 18 years of age or older. Atopic Dermatitis: The member must be 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NERLYNX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has disease progression on Nerlynx (neratinib). Member is taking Nerlynx (neratinib) total treatment for more than one year [applicable only to early stage breast cancer].
Required Medical Information	Early stage Breast Cancer: The member has early stage (i.e. Stage I, II, III) documented HER2 + positive disease AND The member has completed adjuvant therapy with a trastuzumab containing treatment AND Nerlynx (neratinib) is being used for the treatment in extended adjuvant setting. Metastatic Breast Cancer. The member has metastatic or advanced breast cancer and all of the following apply: The member has documented HER2 positive disease and The member has received two or more prior anti-HER2 based regimens in the metastatic setting and Nerlynx (neratinib) is given in combination with capecitabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NESINA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NEULASTA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND The member must have a diagnosis of non-myeloid malignancy (e.g. Solid Tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.

NEULASTA - VIAL (ML)

Part B Prerequisite	0

NEULASTA ONPRO - SYRINGE, WITH WEARABLE INJECTOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND The member must have a diagnosis of non-myeloid malignancy (e.g. Solid Tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.

NEULASTA ONPRO - SYRINGE, WITH WEARABLE INJECTOR

Part B Prerequisite	0

NEUPOGEN - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member had previous treatment or intolerance to both of the following: Zarxio (filgrastim-sndz) and Nivestym (filgrastim-aafi) AND Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

NEUPOGEN - SYRINGE (ML)

Other Criteria	The member must have previous treatment with or intolerance to both of the the following: Zarxio (filgrastim-sndz) and Nivestym (filgrastim-aafi): Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following progenitor-cell transplantation. The member must have had a peripheral-blood progenitor cell (PBPC) transplantation for a non-myeloid malignancy AND The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML). The member must be receiving either induction chemotherapy OR consolidation chemotherapy The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Harvesting of peripheral blood stem cells: The member is using as a component of a hematopoietic stem cell mobilization protocol and one of the following applies: is scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, is storing cells for a possible future autologous transplant, or is donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic: The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia. Neutropenia in Myelodysplastic Syndromes: The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia: The member must have a diagnosis of febrile neutropenia. Filgrastim must be used in adjunct with appropriate antibiotics in high risk patients. Neutropenia in AIDS patients: The member must have a diagnosis of AIDS with neutropenia. Treatment of Aplastic Anemia: The member must have a diagnosis of Aplastic Anemia. Treatment of Agranulocytosis: The member must have a diagnosis of congenital or drug induced agranulocytosis. Hematopoietic Syndrome of Acute radiation syndrome: The member has been acutely exposed to myelosuppressive doses of radiation.
Part B Prerequisite	0

NEURONTIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NEXAVAR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on sorafenib. [Applicable to all indications except Gastrointestinal stromal tumor (GIST)]
Required Medical Information	For Brand Nexavar requests: Member must have an intolerance or contraindication to generic sorafenib. Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma (stage IV). Liver Carcinoma: Diagnosis of unresectable hepatocellular (liver) carcinoma. Thyroid Carcinoma. Diagnosis of advanced metastatic medullary carcinoma (thyroid carcinoma) OR The member has a diagnosis of advanced, clinically progressive and/or symptomatic papillary carcinoma, follicular carcinoma or oncocytic carcinoma AND Tumors are not responsive to radio-iodine treatment. Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NEXICLON XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hypertension: The member must have a diagnosis of hypertension AND the member has had previous treatment, intolerance, or contraindication to clonidine hcl immediate-release tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NEXIUM - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NEXIUM IV - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NEXLETOL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hypercholesterolemia: Diagnosis of hypercholesterolemia (including heterozygous familial hypercholesterolemia [HeFH]) and one of the following: used as adjunctive therapy after failure to achieve goal LDL-C reduction on recommended statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR statin intolerant (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms). Cardiovascular Disease Prevention: Member must have an increased risk of major adverse cardiovascular events AND One of the following: used as adjunctive therapy after failure to achieve goal LDL-C reduction on recommended statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR unable to take recommended statin therapy (e.g. statin intolerance seen through symptoms of rhabdomyolysis or statin-associated muscle symptoms and including those not taking a statin).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NEXLIZET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hypercholesterolemia: Diagnosis of hypercholesterolemia (including heterozygous familial hypercholesterolemia [HeFH]) and one of the following: used as adjunctive therapy after failure to achieve goal LDL-C reduction on recommended statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR statin intolerant (e.g., has symptoms of rhabdomyolysis, statin-associated muscle symptoms). Cardiovascular Disease Prevention: Member must have an increased risk of major adverse cardiovascular events AND One of the following: used as adjunctive therapy after failure to achieve goal LDL-C reduction on recommended statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin) OR unable to take recommended statin therapy (e.g. statin intolerance seen through symptoms of rhabdomyolysis or statin-associated muscle symptoms and including those not taking a statin).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NEXVIAZYME - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Late-Onset Pompe Disease: The member has a diagnosis of late-onset Pompe Disease AND The diagnosis is supported by submission of lab and/or genetic testing consistent with late-onset Pompe disease (e.g. evidence of GAA enzyme deficiency, identification of pathogenic variants in GAA gene).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NGENLA - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

NGENLA - PEN INJECTOR (ML)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

NIKTIMVO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Graft vs Host Disease (cGVHD): The member has a diagnosis of cGVHD AND The member has been unable to achieve treatment goals with at least two prior systemic lines of therapy AND The member must weigh at least 40 kilograms.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NILANDRON - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

nilotinib d-tartrate - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression on any nilotinib (e.g. Tasigna, Danziten).
Required Medical Information	Pending CMS Review
Age Restriction	The member is 18 years or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

nilotinib hcl - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on any nilotinib product. For ALL and CML: The member has one of the following mutations: T315I, Y253H, E255K/V, or F359V/C/I.
Required Medical Information	Chronic Myelogenous Leukemia (CML). The member has a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (CML) AND One of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated, and one of the following applies: Intermediate- or high-risk score for disease progression OR Low-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib OR The members has a diagnosis of chronic phase CML that has received previous treatment AND For brand Tasigna: member must have an intolerance or contraindication to generic nilotinib. Advanced Gastrointestinal Stromal Tumor (GIST). Diagnosis of advanced unresectable GIST. The member has progressive disease or is intolerant to prior therapy with imatinib, sunitinib, or Stivarga (regorafenib) AND For brand Tasigna: member must have an intolerance or contraindication to generic nilotinib. Acute Lymphoblastic Leukemia (ALL). The member has diagnosis of Philadelphia positive acute lymphoblastic leukemia AND For brand Tasigna: member must have an intolerance or contraindication to generic nilotinib. Pediatric CML: Diagnosis of chronic phase Ph+ chronic myeloid leukemia (CML) OR Diagnosis of accelerated phase Ph+ chronic myeloid leukemia (CML) AND resistance, intolerance, or contraindication to prior TKI therapy AND For brand Tasigna: member must have an intolerance or contraindication to generic nilotinib.
Age Restriction	Pediatric CML- member is greater than or equal to 1 year of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NINLARO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with disease progression on Ninlaro (ixazomib).
Required Medical Information	Multiple Myeloma: second line. The member has a diagnosis of relapsed or refractory multiple myeloma AND Ninlaro (ixazomib) will be used after disease progression on at least one prior therapy AND Ninlaro (ixazomib) will be used in combination with lenalidomide and dexamethasone or cyclophosphamide and dexamethasone (Omission of corticosteroid from regimen is allowed if intolerance/contraindication). Multiple Myeloma: third line or subsequent. The member has a diagnosis of relapsed or refractory multiple myeloma AND Ninlaro (ixazomib) will be used after disease progression on at least two prior therapies AND Ninlaro (ixazomib) will be used in combination with pomalidomide and dexamethasone (Omission of corticosteroid from regimen is allowed if intolerance/contraindication) AND The members has demonstrated disease progression on or within 60 days of completion of the last therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

NIVESTYM - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neutropenia in Myelodysplastic Syndromes: The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia: The member must have a diagnosis of febrile neutropenia AND filgrastim product must be used in adjunct with appropriate antibiotics in high risk members. Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimens risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration

NIVESTYM - SYRINGE (ML)

Other Criteria	Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML). The member must be receiving either induction chemotherapy OR consolidation Chemotherapy AND The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following Hematopoietic Stem Cell Transplant (HCST): The member must have had a Hematopoietic Stem Cell Transplant (HCST) (e.g. bone marrow transplant, peripheral-blood progenitor cell (PBPC) transplant) for a non-myeloid malignancy AND The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy Harvesting of peripheral blood stem cells: The member is using as a component of a hematopoietic stem cell mobilization protocol and one of the following applies: is scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, is storing cells for a possible future autologous transplant, or is donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic: The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia. Neutropenia in AIDS patients: The member must have a diagnosis of AIDS with neutropenia. Treatment of Aplastic Anemia: The member must have a diagnosis of Aplastic Anemia. Treatment of Agranulocytosis: The member must have a diagnosis of congenital or drug induced agranulocytosis. Hematopoietic Syndrome of Acute radiation syndrome: The member has been acutely exposed to myelosuppressive doses of radiation.
Part B Prerequisite	0

NORDITROPIN FLEXPRO - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

NORDITROPIN FLEXPRO - PEN INJECTOR (ML)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

norgesic - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Norgesic Forte therapy is not considered medically necessary for members with one of the following concomitant conditions: Glaucoma, GI obstruction (duodenal or pyloric stenosis), achlasia, prostatic hypertrophy, or bladder obstruction, Myasthenia gravis.
Required Medical Information	Relief of mild to moderate pain associated with acute musculoskeletal disorders: the member must be using Norgesic Forte for the relief of mild to moderate pain associated with acute musculoskeletal disorders AND the member has had previous treatment, contraindication or intolerance to baclofen AND tizanidine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NORGESIC FORTE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Norgesic Forte therapy is not considered medically necessary for members with one of the following concomitant conditions: Glaucoma, GI obstruction (duodenal or pyloric stenosis), achlasia, prostatic hypertrophy, or bladder obstruction, Myasthenia gravis.
Required Medical Information	Relief of mild to moderate pain associated with acute musculoskeletal disorders: the member must be using Norgesic Forte for the relief of mild to moderate pain associated with acute musculoskeletal disorders AND the member has had previous treatment, contraindication or intolerance to baclofen AND tizanidine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NORTHERA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neurogenic Orthostatic Hypotension: The member has symptomatic, neurogenic orthostatic hypotension (NOH) caused by: Primary autonomic failure- Parkinson's disease (PD), multiple system atrophy or pure autonomic failure OR Dopamine beta-hydroxylase deficiency OR Non-diabetic neuropathy. AND the member must have had previous treatment, intolerance, or contraindication to one of the following agents: fludrocortisone OR midodrine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NORVASC - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NOURIANZ - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease. The member has a diagnosis of Parkinson's disease AND The member is experiencing "off" periods consistent with Parkinson's AND The member is currently taking carbidopa/levodopa AND Carbidopa/levodopa therapy will be continued concomitantly with Nourianz (istradefylline) AND The member has had previous treatment failure with, contraindication, or intolerance to at least TWO of the following: A dopamine agonist (e.g. pramipexole IR, ropinirole IR) OR A monoamine oxidase-B (MAO-B)inhibitor (e.g. rasagiline, selegiline), OR A catechol-O-methyltransferase (COMT) inhibitor (e.g. entacapone).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NOVAREL - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Obesity, Female or male infertility, Erectile Dysfunction, Precocious puberty, Prostatic carcinoma or other androgen-dependent neoplasm.
Required Medical Information	NA
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

NOXAFIL - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis against Invasive Aspergillus and Candida Infections. The member must be using it for prophylaxis against invasive Aspergillus or Candida infections, and The member must be severely immunocompromised (such as hematopoietic stem cell transplant recipient with graft-vs-host disease, or neutropenic patients with acute myelogenous leukemia (AML) or myelodysplastic syndromes (MDS).Treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes. The member must have documentation for treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes, and The member must have documented resistant strains of or clinically refractory to standard antifungal agents (e.g. voriconazole, itraconazole) or those who can not receive other antifungal agents due to potential toxicities, intolerance, or contraindications. Treatment of Esophageal Candidiasis. The member must have a diagnosis for esophageal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole. Treatment of Oropharyngeal Candidiasis (Suspension only). The member must have a diagnosis for oropharyngeal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

NUBEQA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Nubeqa (darolutamide).
Required Medical Information	Prostate Cancer (non-metastatic castration-resistant): The member has a diagnosis of non-metastatic castration-resistant prostate cancer AND the member will use Nubeqa (darolutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]). Prostate Cancer (metastatic hormone-sensitive prostate cancer): The member has a diagnosis of metastatic hormone-sensitive prostate cancer AND the member will use Nubeqa (darolutamide) alone or with docetaxel AND the member will use Nubeqa (darolutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or LHRH analog [i.e., LHRH agonist/ antagonist]).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NUCALA - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Severe Asthma with an Eosinophilic Phenotype: The member has a diagnosis of severe asthma AND the member has an eosinophilic phenotype, defined by an elevated peripheral blood eosinophil level of greater than or equal to 150 cells/microliter at therapy initiation OR greater than or equal to 300 cells/microliter in the previous 12 months. The member has been unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta agonist (e.g. formoterol). Eosinophilic Granulomatosis with Polyangiitis (EGPA) - Nucala and Fasenra only: The member has a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) AND the member has a baseline elevated peripheral blood eosinophil level of greater than 10% of total leukocyte count AND The member has been unable to achieve adequate control of EGPA while on oral corticosteroid therapy (e.g. prednisone, methylprednisolone). Hypereosinophilic Syndrome (HES) - Nucala only: The member has a diagnosis of hypereosinophilic syndrome (HES) for at least 6 months AND The member has a baseline blood eosinophil level of greater than or equal to 1000 cells/microliter.
Age Restriction	Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

NUCALA - AUTO-INJECTOR (ML)

Other Criteria	Chronic Rhinosinusitis with Nasal Polyposis - Nucala Only: The member must meet ALL of the following criteria: Diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Nucala (mepolizumab) will be used in conjunction with a daily intranasal corticosteroid spray AND member is unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. Chronic Obstructive Pulmonary Disease (COPD) with an eosinophilic phenotype - Nucala only: Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) AND Member has an eosinophilic phenotype defined as an elevated peripheral blood eosinophil level of the following before therapy is started: greater than or equal to 150 cells/microliter OR greater than or equal to 300 cells/microliter in the previous 12 months. Member has been unable to achieve adequate control of COPD while on an: Inhaled corticosteroid therapy in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) OR LABA-LAMA therapy if inhaled corticosteroids are contraindicated.
Part B Prerequisite	0

NUEDEXTA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pseudobulbar Affect: The member has a diagnosis of Pseudobulbar Affect (PBA) due to brain injury or underlying neurologic disease (e.g., stroke, multiple sclerosis, ALS, Parkinson's disease, traumatic brain injury) AND The member is experiencing characteristic behavior episodes (e.g inappropriate laughing or crying) consistent with PBA at baseline AND the provider attests that the risk of QT prolongation with Nuedexta has been considered, and benefits of treatment outweigh risks.
Age Restriction	Member must be 18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NULIBRY - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Molybdenum Cofactor Deficiency Type A. Member is initiating therapy while genetic testing is pending and has a presumed diagnosis of molybdenum cofactor deficiency (MoCD) Type A based on symptoms (e.g. neonatal seizures, feeding difficulties, microcephaly) and biochemical testing (e.g. elevated urinary sulfites or S-sulfocysteine [SSC]) (Applies to initiation of therapy only) OR Member has a diagnosis of MoCD Type A confirmed by genetic testing indicating a mutation in the MOCS1 gene.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	3 months for members pending genetic testing and plan year duration with confirmed genetic testing.
Other Criteria	NA
Part B Prerequisite	0

NUPLAZID - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease Psychosis: The member is using Nuplazid for the treatment of hallucinations and delusions associated with Parkinson's disease (PD) psychosis AND the symptoms of psychosis have appeared after the diagnosis of PD AND psychosis is not related to other causes other than PD.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NURTEC ODT - TABLET,DISINTEGRATING

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Migraine. Will be utilizing Nurtec ODT (rimegepant) for the acute treatment of migraines AND has had previous treatment, intolerance, or contraindication to Ubrelvy. Migraine Prevention: Will be utilizing Nurtec ODT (rimegepant) for the preventative treatment of episodic migraines AND has had previous treatment with Emgality AND Qulipta.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NUTROPIN AQ NUSPIN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

NUTROPIN AQ NUSPIN - PEN INJECTOR (ML)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

NUVIGIL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must utilize Nuvigil (armodafinil) for the treatment of excessive daytime sleepiness or hypersomnolence associated with narcolepsy, obstructive sleep apnea or due to sleep problems resulting from circadian rhythm disruption (i.e., shift-work sleep disorder). For Brand Nuvigil Requests only: The member must have had previous treatment, intolerance, or contraindication to armodafinil or modafinil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

NYPOZI - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member had previous treatment or intolerance to both of the following: Zarxio (filgrastim-sndz) and Nivestym (filgrastim-aafi) AND Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

NYPOZI - SYRINGE (ML)

Other Criteria	The member must have previous treatment with or intolerance to both of the the following: Zarxio (filgrastim-sndz) and Nivestym (filgrastim-aafi): Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following progenitor-cell transplantation. The member must have had a peripheral-blood progenitor cell (PBPC) transplantation for a non-myeloid malignancy AND The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML). The member must be receiving either induction chemotherapy OR consolidation chemotherapy The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Harvesting of peripheral blood stem cells: The member is using as a component of a hematopoietic stem cell mobilization protocol and one of the following applies: is scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, is storing cells for a possible future autologous transplant, or is donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic: The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia. Neutropenia in Myelodysplastic Syndromes: The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia: The member must have a diagnosis of febrile neutropenia. Filgrastim must be used in adjunct with appropriate antibiotics in high risk patients. Neutropenia in AIDS patients: The member must have a diagnosis of AIDS with neutropenia. Treatment of Aplastic Anemia: The member must have a diagnosis of Aplastic Anemia. Treatment of Agranulocytosis: The member must have a diagnosis of congenital or drug induced agranulocytosis. Hematopoietic Syndrome of Acute radiation syndrome: The member has been acutely exposed to myelosuppressive doses of radiation.
Part B Prerequisite	0

NYVEPRIA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND The member must have a diagnosis of non-myeloid malignancy (e.g. Solid Tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.

NYVEPRIA - SYRINGE (ML)

Part B Prerequisite	0

OCALIVA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Biliary Cholangitis: The member has a diagnosis of primary biliary cholangitis (PBC) documented by TWO of the following: Elevated serum alkaline phosphatase level for at least 6 months, Positive antimitochondrial antibody test, or Liver biopsy AND One of the following applies: Member does not have cirrhosis OR has compensated cirrhosis without evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia) AND Member does not have complete biliary obstruction AND Member has never had an episode of decompensated cirrhosis AND One of the following applies: The member has an intolerance to ursodiol OR The member has an inadequate response to an appropriately dosed 1 year trial of ursodiol defined as Alkaline phosphatase greater than or equal to 1.67 times the upper limit of normal, or Total bilirubin greater than the upper limit of normal.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OCREVUS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Progressive Multiple Sclerosis: The member has a definitive diagnosis of primary progressive multiple sclerosis. Relapsing Forms of Multiple Sclerosis: The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), teriflunomide, or a rituximab product (e.g. Riabni, Ruxience).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OCREVUS ZUNOVO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Progressive Multiple Sclerosis: The member has a definitive diagnosis of primary progressive multiple sclerosis. Relapsing Forms of Multiple Sclerosis: The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), teriflunomide, or a rituximab product (e.g. Riabni, Ruxience).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OCTAGAM - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

OCTAGAM - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

octreotide acetate - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For brand Sandostatin subcutaneous: Member has had prior therapy with or intolerance to generic octreotide AND member must meet clinical criteria below. Acromegaly: The member must have a diagnosis of Acromegaly. must have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have grade 3 or above diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine). Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

octreotide,microspheres - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For brand Sandostatin subcutaneous: Member has had prior therapy with or intolerance to generic octreotide AND member must meet clinical criteria below. Acromegaly: The member must have a diagnosis of Acromegaly. must have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have grade 3 or above diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine). Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ODACTRA - TABLET, SUBLINGUAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Allergic Rhinitis with or without Conjunctivitis. Member must have a diagnosis of allergic rhinitis with or without conjunctivitis. Diagnosis has been confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the species contained in the product. Member must have been unable to achieve adequate symptom control with a nasal corticosteroid (e.g. fluticasone) AND a nasal antihistamine (e.g. azelastine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

ODOMZO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Odomzo.
Required Medical Information	Basal Cell Carcinoma: The member has a diagnosis of locally advanced or metastatic basal cell carcinoma AND The member has experienced recurrence or disease progression following surgery or radiation OR has a contraindication to surgery or radiation.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	NA
Part B Prerequisite	0

OFEV - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype: The member has a diagnosis of a Chronic Fibrosing Interstitial Lung Disease [ILD] (e.g., Idiopathic Pulmonary Fibrosis [IPF], Hypersensitivity pneumonitis, Autoimmune ILD, Rheumatoid arthritis-associated ILD [RA-ILD], Systemic Sclerosis-associated ILD [SSc-ILD], Mixed Connective Tissue Disease-associated ILD, Idiopathic non-specific interstitial pneumonia, Unclassifiable Idiopathic Interstitial Pneumonia, Exposure-related ILDs, Sarcoidosis with Fibrosing ILD, in addition to other chronic fibrosing ILDs) confirmed by one of the following: Computer Tomography (CT) with evidence of fibrosis OR Lung Biopsy. Member has a progressive phenotype confirmed by one of the following: Diagnosis is for Idiopathic Pulmonary Fibrosis OR Has had a relative decline in FVC of at least 10% OR worsening respiratory symptoms OR increased extent of fibrotic change on CT scan.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OGIVRI - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Herceptin (trastuzumab), Ogivri, Herzuma or Ontruzant requests: member must have an intolerance or contraindication Trazimera (trastuzumab-qyyp) OR Kanjinti (trastuzumab-anns) and meets below criteria: Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive). Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OGSIVEO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has had disease progression on Ogsiveo (nirogacestat).
Required Medical Information	Desmoid tumors: Member has been diagnosed with progressing desmoid tumor AND Member will be using Ogsiveo (nirogacestat) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OHTUVAYRE - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): The member has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) AND The member is currently on or has had previous treatment, intolerance, or contraindication to a: Long-acting beta agonist [LABA] (e.g. Striverdi Respimat, Brovana, Perforomist) with a concurrent long-acting muscarinic antagonist [LAMA] (e.g. Spiriva Handihaler, Spiriva Respimat, Yupelri) OR LABA-LAMA combination therapy (e.g. Stiolto Respimat, Trelegy Ellipta, Breztri Aerosphere). B vs. D Coverage Determination may be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OJEMDA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on Ojemda (tovorafenib).
Required Medical Information	Pediatric Low-Grade Glioma (pLGG): The member has a diagnosis of relapsed or refractory pediatric low-grade glioma (LGG) AND The member has a documented BRAF fusion or rearrangement, or documented BRAF V600E mutation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OJJAARA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Ojjaara (momelotinib).
Required Medical Information	Myelofibrosis: The member has a diagnosis of primary myelofibrosis or secondary myelofibrosis (i.e. post-polycythemia vera or post-essential thrombocythemia) AND The member has one of the following risk categories, as defined by accepted risk stratification tools for myelofibrosis (e.g. International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or DIPSS-PLUS): Intermediate-risk disease OR High-risk disease AND The member has anemia* AND The member will be using Ojjaara (momelotinib) as monotherapy AND The member has tried, intolerant to, or has a contraindication to Jakafi (Ruxolitinib) or has hemoglobin less than 8 g/dL. *Anemia is defined as hemoglobin less than 10 g/dL or having transfusion-dependent anemia.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OLPRUVA - PELLETS IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Urea Cycle Disorders. The member has a diagnosis of urea cycle disorders (UCDs) AND the member will be using Olpruva (sodium phenylbutyrate oral pellets) in combination with a low protein diet AND the member has tried or cannot use a generic sodium phenylbutyrate product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OLUMIANT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis: The member has a diagnosis of moderate to severely active rheumatoid arthritis. The member has had previous treatment, contraindication, or intolerance to two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Alopecia Areata: The member has a diagnosis of severe alopecia areata evidenced by at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT) for more than 6 months AND the member has had previous treatment, contraindication, or intolerance to corticosteroids (e.g. betamethasone valerate lotion) or cyclosporine capsules.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OLUX - FOAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OLUX-E - FOAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OMNITROPE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

OMNITROPE - VIAL (EA)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

OMVOH - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with intravenous Omvoh. Crohns Disease: The member has a diagnosis of moderately to severely active Crohns Disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with intravenous Omvoh.
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OMVOH - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohns Disease: The member has a diagnosis of moderately to severely active Crohns Disease AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OMVOH PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with intravenous Omvoh. Crohns Disease: The member has a diagnosis of moderately to severely active Crohns Disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with intravenous Omvoh.
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ONAPGO - CARTRIDGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Advanced Parkinsons Disease: The member must have a diagnosis of advanced Parkinsons disease AND The member is experiencing persistent motor fluctuations despite optimized carbidopa/levodopa therapy AND The member has tried or cannot use one of the following anti-Parkinson agents: Catechol-D-methyl transferase (COMT) inhibitor (e.g., entacapone), Monoamine oxidase B (MAO)-B inhibitor (e.g., rasagiline, selegiline), Dopamine agonists (e.g., pramipexole, ropinirole), or Amantadine. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ONCASPAR - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on or following Oncaspar. Members with a history of serious thrombosis with prior asparaginase therapy. Members with a history of pancreatitis with prior asparaginase therapy. Members with a history of serious hemorrhagic events with prior asparaginase therapy. Members with total bilirubin more than 10 times the upper limit of normal.
Required Medical Information	Acute Lymphoblastic Leukemia: The member has a diagnosis of acute lymphoblastic leukemia (ALL) AND the member will be using Oncaspar (pegaspargase) as a component of a multi-agent chemotherapy regimen.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA
Part B Prerequisite	0

ONFI - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND Onfi (clobazam) will be used in combination with at least one other drug for controlling seizures AND The member has been unable to achieve seizure control with at least one other drug used for the adjunctive treatment of Lennox-Gastaut syndrome (e.g., lamotrigine, rufinamide, topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ONGENTYS - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's disease "Off" episodes: The member has a diagnosis of Parkinson's disease AND the member is taking carbidopa/levodopa AND Ongentys will be taken in combination with carbidopa/levodopa AND The member is experiencing "off" episodes associated with Parkinson's disease therapy AND The member has tried or cannot use an entacapone containing medication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ONIVYDE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Monotherapy with Onivyde (liposomal irinotecan). Members that have experienced disease progression while on Onivyde (liposomal irinotecan).
Required Medical Information	Pancreatic Cancer (First-line Therapy): The member has a diagnosis of metastatic adenocarcinoma of the pancreas AND Onivyde (liposomal irinotecan) will be used as first-line therapy AND The member will be using Onivyde (liposomal irinotecan) in combination with oxaliplatin, fluorouracil and leucovorin. Pancreatic Cancer (Subsequent Therapy): The member has a diagnosis of metastatic adenocarcinoma of the pancreas AND The member has previously received gemcitabine based therapy or fluoropyrimidine based therapy (not including irinotecan) and experienced disease progression AND The member will be using Onivyde (liposomal irinotecan) in combination with fluorouracil and leucovorin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ONPATTRO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Transthyretin-Mediated Amyloidosis: Member must meet ALL of the following criteria: Documentation in the medical record of a mutation in the TTR gene, AND Currently experiences polyneuropathy and a comprehensive neurologic examination has ruled out other known causes of sensorimotor/autonomic neuropathy (e.g., chronic inflammatory demyelinating polyneuropathy) AND Polyneuropathy disability score of IIIb or lower AND Does not have history of a previous liver transplant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ONTRUZANT - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Herceptin (trastuzumab), Ogivri, Herzuma or Ontruzant requests: member must have an intolerance or contraindication Trazimera (trastuzumab-qyyp) OR Kanjinti (trastuzumab-anns) and meets below criteria: Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive). Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ONUREG - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression on hypomethylators (e.g. azacitidine, decitabine).
Required Medical Information	Acute Myeloid Leukemia: The member has a diagnosis of acute myeloid leukemia AND The member is using Onureg (azacitidine) for post-remission therapy AND The member has achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy AND The member is not able to complete or declines intensive curative therapy (e.g. allogeneic hematopoietic stem cell transplant) AND The member will use Onureg (azacitidine) as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OPDIVO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	All indications except Hepatocellular carcinoma, MSI-H or dMMR: Disease progression while on or following anti-PD-1/PD-L1 therapy (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab], Bavencio [avelumab]). Adjuvant melanoma only: member is taking Opdivo (nivolumab) total treatment for more than one year. Neoadjuvant NSCLC only: member is taking Opdivo (nivolumab) total treatment in combination with platinum-doublet chemotherapy for more than 3 cycles. Hepatocellular carcinoma: Disease progression while on or following anti-PD-1/PD-L1 combination therapy (e.g. Imjudo [tremelimumab-actl] with Imfinzi [durvalumab]). MSI-H or dMMR: Disease progression while on or following anti-PD-1/PD-L1 combination therapy (e.g. Opdivo [nivolumab] with Yervoy [ipilimumab]).
Required Medical Information	Melanoma: diagnosis of unresectable or metastatic melanoma AND using as monotherapy OR in combo with Yervoy (ipilimumab) followed by Opdivo (nivolumab) or Opdivo Qvantig (nivolumab and hyaluronidase-nvhy) monotherapy. Melanoma-Adjuvant: diagnosis of stage IIB, IIC, III or stage IV melanoma AND undergone complete resection of disease AND using as adjuvant treatment AND using as monotherapy. Non-Small Cell Lung Cancer-subsequent therapy: diagnosis of metastatic squamous or non-squamous NSCLC AND experienced disease progression on or after chemo and EGFR inhibitor, if EGFR mutation positive or ALK inhibitor, if ALK positive AND using as monotherapy. Renal Cell Carcinoma (RCC): diagnosis of advanced RCC AND one of the following applies: will be using as subsequent therapy AND has received prior anti-angiogenic therapy OR Will be using in combo with Yervoy followed by Opdivo or Opdivo Qvantig monotherapy as first line therapy OR Will be using in combo with Cabometyx (cabozantinib) as first line therapy. Classical Hodgkin Lymphoma: diagnosis of classical Hodgkin Lymphoma AND one of the following applies: has relapsed or refractory disease AND using as monotherapy or in combo with a supported combo therapy OR has newly diagnosed disease AND using in combo with doxorubicin, vinblastine and dacarbazine. Non-Small Cell Lung Cancer (NSCLC)-Perioperative: diagnosis of NSCLC AND must not have any known epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) rearrangements AND must have resectable disease (tumors greater than or equal to 4 cm or node positive) AND using in the neoadjuvant setting, in combo with platinum-doublet chemo followed by Opdivo or Opdivo Qvantig as monotherapy. Hepatocellular Carcinoma: The member has a diagnosis of hepatocellular carcinoma AND using in combo with Yervoy followed by Opdivo or Opdivo Qvantig monotherapy.
Age Restriction	

OPDIVO - VIAL (ML)

Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

OPDIVO - VIAL (ML)

Other Criteria	Non-nasopharyngeal recurrent or metastatic Squamous Cell Carcinoma of the Head and Neck (SCCHN) AND using as monotherapy AND disease progression on or after platinum based therapy. Locally advanced or metastatic urothelial cancer AND using as monotherapy AND 1 of the following apply: used as 2nd or subsequent line-therapy OR Disease progression within 12 months of neoadjuvant or adjuvant chemo OR high risk of recurrence after radical surgical resection of disease. Unresectable or metastatic urothelial carcinoma AND in combo with cisplatin and gemcitabine, followed by monotherapy maintenance. Unresectable or metastatic colorectal cancer with documented Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) AND 1 of the following applies: disease progressed following treatment with oxaliplatin-, irinotecan-, or fluoropyrimidine-based therapy and will be using Opdivo or Opdivo Qvantig as monotherapy OR using in combo with Yervoy, followed by Opdivo or Opdivo Qvantig as monotherapy. Non-small cell lung cancer (NSCLC) 1st Line Therapy: metastatic NSCLC AND 1 of the following applies: Disease with PD-L1 expression greater than or equal to 1% with no EGFR or ALK genomic tumor aberrations and given as 1st line therapy AND Tumor expresses PD-L1 as determined by FDA-approved test AND in combo with Yervoy OR Disease with no EGFR or ALK genomic tumor aberrations and given as 1st line therapy AND in combo with Yervoy AND used in combo with 2 cycles of platinum doublet chemo. Esophageal cancer: unresectable advanced, recurrent, or metastatic squamous cell carcinoma of the esophagus and 1 of the following apply: disease progressed after prior fluoropyrimidine- and platinum-based chemo AND will be given as subsequent monotherapy OR in combo with fluoropyrimidine- and platinum containing chemo for 1st line treatment AND the tumor expressed PD-L1 great than or equal to 1 OR as 1st line treatment Opdivo in combo with Yervoy AND the tumor expressed PD-L1 great than or equal. Unresectable malignant pleural mesothelioma AND 1 of the following scenarios applies: 1st-line treatment AND in combo with Yervoy OR as subsequent treatment, if not administered 1st-line AND as single agent OR in combo with Yervoy. Gastric Cancer, Gastroesophageal Junction Cancer, and Esophageal Adenocarcinoma (advanced or metastatic): given with a regimen containing fluoropyrimidine- and platinum-based chemo AND the tumor expressed PD-L1 great than or equal. Esophageal or Gastroesophageal Junction cancer (residual disease post-surgery and preoperative chemoradiation): received neoadjuvant chemoradiation AND complete surgical resection of esophageal or gastroesophageal junction AND has residual pathologic disease AND given as subsequent monotherapy. NSCLC- Neoadjuvant Therapy: early stage NSCLC AND has resectable disease (tumors greater than 4 cm or node positive) AND using in neoadjuvant setting, in combo with platinum-doublet chemo.
Part B Prerequisite	0

OPDIVO QVANTIG - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	All indications except Hepatocellular carcinoma, MSI-H or dMMR: Disease progression while on or following anti-PD-1/PD-L1 therapy (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab], Bavencio [avelumab]). Adjuvant melanoma only: member is taking Opdivo Qvantig (nivolumab and hyaluronidase-nvhy) total treatment for more than one year. Neoadjuvant NSCLC only: member is taking Opdivo Qvantig (nivolumab and hyaluronidase-nvhy) total treatment in combination with platinum-doublet chemotherapy for more than 3 cycles. Hepatocellular carcinoma: Disease progression while on or following anti-PD-1/PD-L1 combination therapy (e.g. Imjudo [tremelimumab-actl] with Imfinzi [durvalumab]). MSI-H or dMMR: Disease progression while on or following anti-PD-1/PD-L1 combination therapy (e.g. Opdivo [nivolumab] with Yervoy [ipilimumab]).
Required Medical Information	Melanoma: diagnosis of unresectable or metastatic melanoma AND using as monotherapy OR Opdivo (nivolumab) in combo with Yervoy (ipilimumab) followed by Opdivo Qvantig (nivolumab and hyaluronidase-nvhy) monotherapy. Melanoma-Adjuvant: diagnosis of stage IIB, IIC, III or stage IV melanoma AND undergone complete resection of disease AND using as adjuvant treatment AND using as monotherapy. Non-Small Cell Lung Cancer-subsequent therapy: diagnosis of metastatic squamous or non-squamous NSCLC AND experienced disease progression on or after chemo and EGFR inhibitor, if EGFR mutation positive or ALK inhibitor, if ALK positive AND using as monotherapy. Renal Cell Carcinoma (RCC): diagnosis of advanced RCC AND one of the following applies: will be using as subsequent therapy AND has received prior anti-angiogenic therapy OR Opdivo (nivolumab) using in combo with Yervoy followed by Opdivo Qvantig monotherapy as first line therapy OR Will be using in combo with Cabometyx (cabozantinib) as first line therapy. Non-Small Cell Lung Cancer (NSCLC)-Perioperative: diagnosis of NSCLC AND must not have any known epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) rearrangements AND must have resectable disease (tumors greater than or equal to 4 cm or node positive) AND using in the neoadjuvant setting, in combo with platinum-doublet chemo followed by Opdivo or Opdivo Qvantig as monotherapy. Hepatocellular Carcinoma: The member has a diagnosis of hepatocellular carcinoma AND Opdivo (nivolumab) using in combo with Yervoy, followed by Opdivo Qvantig monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner

OPDIVO QVANTIG - VIAL (ML)

Coverage Duration	6 months duration
Other Criteria	Non-nasopharyngeal recurrent or metastatic Squamous Cell Carcinoma of the Head and Neck (SCCHN) AND using as monotherapy AND disease progression on or after platinum based therapy. Locally advanced or metastatic urothelial cancer AND using as monotherapy AND 1 of the following apply: used as 2nd or subsequent line-therapy OR Disease progression within 12 months of neoadjuvant or adjuvant chemo OR high risk of recurrence after radical surgical resection of disease. Unresectable or metastatic urothelial carcinoma AND in combo with cisplatin and gemcitabine, followed by monotherapy maintenance. Unresectable or metastatic colorectal cancer with documented Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) AND 1 of the following applies: disease progressed following treatment with oxaliplatin-, irinotecan-, or fluoropyrimidine-based therapy and will be as monotherapy OR Opdivo (nivolumab) using in combo with Yervoy, followed by Opdivo Qvantig as monotherapy. Non-small cell lung cancer (NSCLC) 1st Line Therapy: metastatic NSCLC AND 1 of the following applies: Disease with PD-L1 expression greater than or equal to 1% with no EGFR or ALK genomic tumor aberrations and given as 1st line therapy AND Tumor expresses PD-L1 as determined by FDA-approved test OR Disease with no EGFR or ALK genomic tumor aberrations and given as 1st line therapy AND used in combo with 2 cycles of platinum doublet chemo. Esophageal cancer: unresectable advanced, recurrent, or metastatic squamous cell carcinoma of the esophagus and 1 of the following apply: disease progressed after prior fluoropyrimidine- and platinum-based chemo AND will be given as subsequent monotherapy OR in combo with fluoropyrimidine- and platinum containing chemo for 1st line treatment AND the tumor expressed PD-L1 great than or equal to 1. Gastric Cancer, Gastroesophageal Junction Cancer, and Esophageal Adenocarcinoma (advanced or metastatic): given with a regimen containing fluoropyrimidine- and platinum-based chemo AND the tumor expressed PD-L1 great than or equal. Esophageal or Gastroesophageal Junction cancer (residual disease post-surgery and preoperative chemoradiation): received neoadjuvant chemoradiation AND complete surgical resection of esophageal or gastroesophageal junction AND has residual pathologic disease AND given as subsequent monotherapy. NSCLC- Neoadjuvant Therapy: early stage NSCLC AND has resectable disease (tumors greater than 4 cm or node positive) AND using in neoadjuvant setting, in combo with platinum-doublet chemo.
Part B Prerequisite	0

OPDUALAG - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression while on or following prior anti-PD-1/PD-L1 combination therapy (e.g., nivolumab with ipilimumab). Members on concomitant Zelboraf (vemurafenib), Tafinlar (dabrafenib), Mekinist (trametinib) or Cotellic (cobimetinib) therapy. Safety and efficacy have not been established.
Required Medical Information	Melanoma: Unresectable or metastatic melanoma: The member must have a diagnosis of unresectable or metastatic melanoma AND Opdualag is administered as monotherapy.
Age Restriction	The member must be 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

OPFOLDA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Late Onset Pompe Disease. The member has a diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) AND The member weighs 40 kg or greater AND The member is not improving on current enzyme replacement therapy (ERT)(e.g. Nexviazyme (avalglucosidase alfa ngpt), Lumizyme (alglucosidase alfa)) AND The member is using Pombiliti in combination with Opfolda (Miglustat).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OPIPZA - FILM, MEDICATED (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia: The member has clinically diagnosed schizophrenia AND The member has tried or cannot use at least two of the following generic atypical antipsychotics: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Major Depressive Disorder (MDD): The member has clinically diagnosed major depressive disorder (MDD) AND The member has tried or cannot use generic aripiprazole in combination with at least one product considered antidepressant therapy (ADT) AND Oipza will be used as adjunctive or add-on treatment to ADT and not as monotherapy. Irritability associated with Autistic Disorder or Tourette's Disorder: The member has one of the following clinically diagnosed conditions: Irritability associated with autistic disorder OR Tourette's disorder.
Age Restriction	Schizophrenia: The member is 13 years of age or older. MDD: The member is 18 years of age or older. Irritability associated with Autistic Disorder or Tourette's Disorder: The member is 6 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OPSUMIT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OPSYNVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OPZELURA - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: Member has a diagnosis of mild to moderate atopic dermatitis AND Is not immunocompromised AND Has had previous treatment, intolerance, or contraindication to a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol cream/ointment) AND Has had previous treatment, intolerance, or contraindication to a topical calcineurin inhibitor (e.g. tacrolimus). Nonsegmental vitiligo: the member must meet all of the following criteria: diagnosis of nonsegmental vitiligo, have a maximum treatment body surface area (BSA) of less than or equal to 10%, previous treatment, intolerance, or contraindication to a nonsegmental vitiligo treatment (e.g. topical corticosteroids, topical calcineurin inhibitor) OR Prescriber determines that depigmentation affects the facial area where application of a topical high-potency steroid would be inappropriate.
Age Restriction	
Prescriber Restriction	Licensed Practitioner. Nonsegmental vitiligo: Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ORENCIA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: The member must have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya.
Age Restriction	Member must be 18 and older for RA. Member must be 2 years of age and older for PsA and PJIA.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORENCIA CLICKJECT - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: The member must have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya.
Age Restriction	Member must be 18 and older for RA. Member must be 2 years of age and older for PsA and PJIA.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORENITRAM - TABLET, EXTENDED RELEASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization. AND The member must have had prior therapy, intolerance, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g. sildenafil or tadalafil) or Adempas (riociguat) AND ONE Endothelin receptor antagonist (e.g. ambrisentan, bosentan, macitentan) approved for use in PAH AND The member has had prior therapy, intolerance, or contraindication to Tyvaso DPI (treprostinil) OR Uptravi (selexipag).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORENITRAM MONTH 1 TITRATION KT - TABLET, EXTENDED RELEASE, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization. AND The member must have had prior therapy, intolerance, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g. sildenafil or tadalafil) or Adempas (riociguat) AND ONE Endothelin receptor antagonist (e.g. ambrisentan, bosentan, macitentan) approved for use in PAH AND The member has had prior therapy, intolerance, or contraindication to Tyvaso DPI (treprostinil) OR Uptravi (selexipag).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORENITRAM MONTH 2 TITRATION KT - TABLET, EXTENDED RELEASE, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization. AND The member must have had prior therapy, intolerance, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g. sildenafil or tadalafil) or Adempas (riociguat) AND ONE Endothelin receptor antagonist (e.g. ambrisentan, bosentan, macitentan) approved for use in PAH AND The member has had prior therapy, intolerance, or contraindication to Tyvaso DPI (treprostinil) OR Uptravi (selexipag).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORENITRAM MONTH 3 TITRATION KT - TABLET, EXTENDED RELEASE, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization. AND The member must have had prior therapy, intolerance, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g. sildenafil or tadalafil) or Adempas (riociguat) AND ONE Endothelin receptor antagonist (e.g. ambrisentan, bosentan, macitentan) approved for use in PAH AND The member has had prior therapy, intolerance, or contraindication to Tyvaso DPI (treprostinil) OR Uptravi (selexipag).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORGOVYX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs. Pediatric members less than 18 years old.
Required Medical Information	Prostate Cancer: The member has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORIAHNN - CAPSULE, SEQUENTIAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Known osteoporosis. Greater than 24 months of therapy will not be permitted based on dosing information on label.
Required Medical Information	Heavy Menstrual Bleeding Associated with Uterine Leiomyomas: The member must be premenopausal AND The member must have a diagnosis of uterine leiomyomas (fibroids) AND The member must be experiencing heavy menstrual bleeding associated with uterine fibroids AND The member has had previous treatment, contraindication, or intolerance with tranexamic acid tablet . Moderate to severe pain associated with endometriosis (Myfembree only): the member must have a diagnosis of endometriosis AND the member must have moderate to severe pain associated with endometriosis AND the member must be premenopausal AND the member has had previous treatment, contraindication, or intolerance with a hormone contraceptive (e.g. drospirenone-ethinyl estradiol, norethindrone acetate-ethinyl estradiol) or nonsteroidal anti-inflammatory (e.g. naproxen, ibuprofen).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

ORILISSA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Osteoporosis or metabolic bone disease. Greater than 6 months of therapy (200mg) or 24 months of therapy (150mg) will not be permitted based on dosing information on label.
Required Medical Information	Moderate to Severe Pain Associated with Endometriosis. The member has a diagnosis of endometriosis AND The member must have moderate to severe pain associated with endometriosis AND The member must be premenopausal AND The member has had previous treatment, contraindication, or intolerance with a hormonal contraceptive (e.g. drospirenone-ethinyl estradiol, norethindrone acetateethinyl estradiol) OR nonsteroidal anti-inflammatory (e.g. naproxen, ibuprofen).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

ORKAMBI - GRANULES IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis: The member must meet ALL of the following criteria: Diagnosis of Cystic Fibrosis AND Prior lab testing with documentation of a mutation in the CFTR gene that is responsive to therapy based on clinical literature and/or in vitro assay data AND Previous treatment, contraindication, or intolerance to Trikafta.
Age Restriction	
Prescriber Restriction	The member is being treated by or in consultation with a specialist (e.g. pulmonologist).
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORLADEYO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Prophylaxis: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member is using Orladeyo for prophylaxis to prevent attacks of HAE. The member has had previous treatment, contraindication, or intolerance with appropriately dosed Haegarda (C1 esterase inhibitor, human) for HAE prophylaxis. Documentation details must be submitted for one of the following: trial of Haegarda and the member's response, member's specific contraindication to Haegarda, OR describing the side effects observed with Haegarda.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ormalvi - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Periodic paralysis: The member must have a diagnosis of primary hyperkalemic or hypokalemic periodic paralysis, or variants of periodic paralysis (i.e. Paramyotonia Congenita, Andersen-Tawil Syndrome) AND The member has had previous treatment, contraindication, or intolerance with acetazolamide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

orphenadrine-asa-caffeine - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Norgesic Forte therapy is not considered medically necessary for members with one of the following concomitant conditions: Glaucoma, GI obstruction (duodenal or pyloric stenosis), achlasia, prostatic hypertrophy, or bladder obstruction, Myasthenia gravis.
Required Medical Information	Relief of mild to moderate pain associated with acute musculoskeletal disorders: the member must be using Norgesic Forte for the relief of mild to moderate pain associated with acute musculoskeletal disorders AND the member has had previous treatment, contraindication or intolerance to baclofen AND tizanidine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

orphengestic forte - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Norgesic Forte therapy is not considered medically necessary for members with one of the following concomitant conditions: Glaucoma, GI obstruction (duodenal or pyloric stenosis), achlasia, prostatic hypertrophy, or bladder obstruction, Myasthenia gravis.
Required Medical Information	Relief of mild to moderate pain associated with acute musculoskeletal disorders: the member must be using Norgesic Forte for the relief of mild to moderate pain associated with acute musculoskeletal disorders AND the member has had previous treatment, contraindication or intolerance to baclofen AND tizanidine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ORSERDU - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Estrogen Receptor (ER)- positive Breast Cancer: The member has ER-positive, HER2-negative advanced or metastatic breast cancer AND the breast cancer has documented ESR1-mutation as determined by FDA approved test AND the member has progressive disease following at least one prior line endocrine therapy (e.g., fulvestrant, CDK 4/6 inhibitor) AND Orserdu (elacestrant) is given as single agent as subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

OSENI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OSMOLEX ER - TABLET,IMMED AND EXTEND REL BIPHASE 24HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Idiopathic Parkinsonism or Parkinson's disease. The member has a diagnosis of Parkinson's disease or idiopathic parkinsonism AND The member must be able to tolerate at least 100mg of immediate-release amantadine AND The member has had an inadequate symptom improvement with immediate-release amantadine. Drug-induced extrapyramidal reactions. The member has a diagnosis of drug-induced extrapyramidal reactions AND The member must be able to tolerate at least 100mg of immediate-release amantadine AND The member has had inadequate extrapyramidal symptom improvement with immediate-release amantadine AND The member did not achieve extrapyramidal symptom improvement following dose reduction or discontinuation of offending agent OR the member is unable to discontinue or reduce the dose of the offending agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OSPHENA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must be post-menopausal. The member must have vulvar and/or vaginal atrophy AND one of the following: moderate to severe dyspareunia or moderate to severe vaginal dryness. The member has had a previous treatment, intolerance or contraindication to estradiol vaginal cream or Premarin vaginal cream.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OTEZLA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member must weight 20 kg or greater. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Mild Plaque Psoriasis: The member has a diagnosis of mild plaque psoriasis (e.g. involvement of less than 3% of body surface area) AND member has had prior therapy, contraindication, or intolerance with a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol cream/ointment) AND has had prior therapy, contraindication, or intolerance with a topical vitamin D product (e.g. calcipotriene cream or solution). Moderate to Severe Plaque Psoriasis: The member has a diagnosis of moderate-to-severe plaque psoriasis. The member must weigh 20 kg or greater. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND Otezla (apremilast) will be used for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Age Restriction	Member is 18 years of age or older for treatment of oral ulcers associated with Behcet's Disease and mild plaque psoriasis. Member is 6 years of age or older for treatment of moderate to severe plaque psoriasis and psoriatic arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OTEZLA STARTER - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member must weight 20 kg or greater. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Mild Plaque Psoriasis: The member has a diagnosis of mild plaque psoriasis (e.g. involvement of less than 3% of body surface area) AND member has had prior therapy, contraindication, or intolerance with a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol cream/ointment) AND has had prior therapy, contraindication, or intolerance with a topical vitamin D product (e.g. calcipotriene cream or solution). Moderate to Severe Plaque Psoriasis: The member has a diagnosis of moderate-to-severe plaque psoriasis. The member must weigh 20 kg or greater. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND Otezla (apremilast) will be used for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Age Restriction	Member is 18 years of age or older for treatment of oral ulcers associated with Behcet's Disease and mild plaque psoriasis. Member is 6 years of age or older for treatment of moderate to severe plaque psoriasis and psoriatic arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OTEZLA XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member must weight 20 kg or greater. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Mild Plaque Psoriasis: The member has a diagnosis of mild plaque psoriasis (e.g. involvement of less than 3% of body surface area) AND member has had prior therapy, contraindication, or intolerance with a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol cream/ointment) AND has had prior therapy, contraindication, or intolerance with a topical vitamin D product (e.g. calcipotriene cream or solution). Moderate to Severe Plaque Psoriasis: The member has a diagnosis of moderate-to-severe plaque psoriasis. The member must weigh 20 kg or greater. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND Otezla (apremilast) will be used for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Age Restriction	Member is 18 years of age or older for treatment of oral ulcers associated with Behcet's Disease and mild plaque psoriasis. Member is 6 years of age or older for treatment of moderate to severe plaque psoriasis and psoriatic arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OTEZLA XR INITIATION - TABLET AND TABLET ER DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. The member must weight 20 kg or greater. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Mild Plaque Psoriasis: The member has a diagnosis of mild plaque psoriasis (e.g. involvement of less than 3% of body surface area) AND member has had prior therapy, contraindication, or intolerance with a high potency topical corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol cream/ointment) AND has had prior therapy, contraindication, or intolerance with a topical vitamin D product (e.g. calcipotriene cream or solution). Moderate to Severe Plaque Psoriasis: The member has a diagnosis of moderate-to-severe plaque psoriasis. The member must weigh 20 kg or greater. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Oral Ulcers Associated with Behcets Disease: The member has a diagnosis of Behcets disease AND Otezla (apremilast) will be used for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Age Restriction	Member is 18 years of age or older for treatment of oral ulcers associated with Behcet's Disease and mild plaque psoriasis. Member is 6 years of age or older for treatment of moderate to severe plaque psoriasis and psoriatic arthritis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OTREXUP (PF) - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis. The member has a diagnosis of severe active rheumatoid arthritis AND the member has previous treatment, or intolerance with generic methotrexate. Polyarticular Juvenile Idiopathic Arthritis (pJIA).The member has a diagnosis of active pJIA AND the member has previous treatment, or intolerance with generic methotrexate. Psoriasis: The member has a diagnosis of active severe, recalcitrant, disabling psoriasis AND The member has previous treatment, or intolerance with generic methotrexate.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OTULFI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis (SC formulation only): The member must have a diagnosis of moderate to severe chronic plaque psoriasis AND The member has had prior therapy or intolerance to one or more oral systemic treatments (e.g. methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Psoriatic arthritis (SC formulation only): The member must have a diagnosis of active psoriatic arthritis. Moderately to severely active Crohn's disease (IV and SC formulations). The member must have a diagnosis of moderately to severely active Crohn's disease. Moderate to severely active ulcerative colitis (IV and SC formulations): The member must have a diagnosis of moderately to severely active ulcerative colitis.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

OVIDE - LOTION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OXERVATE - DROPS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neurotrophic Keratitis. Initial Authorization: The member has a diagnosis of Neurotrophic Keratitis AND Is not requesting more than 8 weeks of Oxervate (cenegermin) treatment in the affected eye(s). Reauthorization: Has not previously received a total of 8 weeks of Oxervate (cenegermin) treatment in the affected eye(s).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

oxiconazole - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must be using the requested antifungal topically for the treatment of an active susceptible fungal infection AND has had previous treatment, contraindication, or intolerance to two of the following: clotrimazole cream, ciclopirox 0.77% cream/gel/suspension, or ketoconazole cream.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OXISTAT - LOTION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must be using the requested antifungal topically for the treatment of an active susceptible fungal infection AND has had previous treatment, contraindication, or intolerance to two of the following: clotrimazole cream, ciclopirox 0.77% cream/gel/suspension, or ketoconazole cream.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

OXLUMO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Hyperoxaluria Type 1 (PH1): Initial Criteria - Member has a diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by one of the following: Genetic testing showing biallelic pathogenic variants in AGXT or Identification of AGT enzyme deficiency on liver biopsy AND Has elevated oxalate levels (e.g. urine oxalate excretion greater than 0.5 mmol (or 45 mg)/1.73 m2/day, urinary oxalate/creatinine ratio above the laboratory's age specific reference range, or plasma oxalate level greater than 2 micromol/L) AND Prescribed by or in consultation with a nephrologist, urologist, geneticist, or other provider with experience managing primary hyperoxaluria AND Has not received a liver transplant. Continuation: The member has a clinical response to Oxlumo therapy as demonstrated by one of the following: Reduced urinary or plasma oxalate levels from initiation of Oxlumo or Reduced urinary oxalate/creatinine ratio from initiation of Oxlumo AND Has not received a liver transplant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial Auth: 6 Months Duration. Reauth: Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

oxycodone - TABLET, ORAL ONLY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute or Chronic Pain: Has pain severe enough to require an opioid pain medication and for which alternative treatments are inadequate AND Has had previous treatment, contraindication, or intolerance to at least TWO of the following immediate-release opioids: oxycodone (non-abuse deterrent formulation), hydromorphone, OR morphine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

oxycodone-acetaminophen - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Pain: Has pain severe enough to require an opioid pain medication and for which alternative treatments are inadequate AND Has had previous treatment, contraindication, or intolerance to BOTH of the following: hydrocodone-325mg acetaminophen tablet (e.g., generic Norco) AND oxycodone-325mg acetaminophen tablet (e.g., generic Percocet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Pain: Has pain severe enough to require an opioid pain medication and for which alternative treatments are inadequate AND Has had previous treatment, contraindication, or intolerance to BOTH of the following: hydrocodone-325mg acetaminophen tablet (e.g., generic Norco) AND oxycodone-325mg acetaminophen tablet (e.g., generic Percocet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

oxycodone-acetaminophen - SOLUTION, ORAL

Other Criteria	
Part B Prerequisite	0

OZEMPIC - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using for weight loss.
Required Medical Information	Diabetes Mellitus. The member has a diagnosis of type 2 diabetes mellitus.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

paclitaxel protein-bound - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Breast Cancer. The member has a diagnosis of metastatic (Stage IV) or recurrent breast cancer. The member received prior therapy that included an anthracycline (e.g. doxorubicin, epirubicin). The member has documented hypersensitivity reaction to conventional paclitaxel or docetaxel or the member has a documented contraindication to standard hypersensitivity premedications. Non-small Cell Lung Cancer (NSCLC) [Squamous Cell Histology]. The member has a diagnosis of locally advanced, recurrent or metastatic NSCLC. Member has documented hypersensitivity reaction to conventional paclitaxel or docetaxel or the member has a documented contraindication to standard hypersensitivity premedications AND member has squamous histology where nab-paclitaxel will be given in combo with Keytruda (pembrolizumab) and carboplatin as first line therapy. Non-small Cell Lung Cancer (NSCLC). The member has a diagnosis of locally advanced, recurrent or metastatic NSCLC. One of the following applies: The member will be using nab-paclitaxel as monotherapy or in combination with carboplatin AND One of the following apply: will be using for first line therapy OR member will be using as subsequent therapy AND The member has documented hypersensitivity reaction to conventional paclitaxel or docetaxel or the member has a documented contraindication to standard hypersensitivity premedications OR member has metastatic NSCLC, non- squamous histology with no EGFR or ALK genomic tumor aberrations AND nab-paclitaxel will be given combo with Tecentriq (atezolizumab) and carboplatin as first line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration

paclitaxel protein-bound - VIAL (EA)

Other Criteria	Ovarian Cancer. The member has a diagnosis of epithelial ovarian cancer, fallopian tube cancer or primary peritoneal cancer. The member meets one of the following criteria: Progressive, stable or persistent disease on primary chemotherapy OR Recurrent disease. The member has documented hypersensitivity reaction to conventional paclitaxel or docetaxol or the member has a documented contraindication to standard hypersensitivity premedications. Pancreatic Cancer: The member has a diagnosis of pancreatic cancer and nab-paclitaxel is being used in combination with gemcitabine as neoadjuvant therapy or The member has a diagnosis of metastatic pancreatic cancer AND The member will be using nab-paclitaxel in combination with gemcitabine. Melanoma: The member has a diagnosis of unresectable or metastatic melanoma AND The member will be using nab-paclitaxel as second-line or subsequent therapy after progression on prior therapy AND The member has documented hypersensitivity reaction to conventional paclitaxel or docetaxol or the member has a documented contraindication to standard hypersensitivity premedications.
Part B Prerequisite	0

PADCEV - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Bladder Cancer. The member has locally advanced or metastatic bladder cancer AND one of the following applies: The member will be using Padcev (enfortumab vedotin-ejfv) as monotherapy AND The member has received prior treatment with a platinum-containing chemotherapy AND The member has received previous treatment with a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor OR The member has previously received one or more prior lines of therapy AND The member is ineligible for cisplatin-containing chemotherapy* OR the member is receiving Padcev (enfortumab vedotin-ejfv) in combination with Keytruda (pembrolizumab) in the front-line setting. *Cisplatin-ineligible comorbidities may include the following: CCrCl less than 60 mL/min, PS greater than or equal to 2, hearing loss of greater than or equal to 25 decibels (dB) at two contiguous frequencies, grade greater than or equal to 2 peripheral neuropathy, or NYHA class greater than or equal to 3. Carboplatin may be substituted for cisplatin particularly in those patients with a CrCl less 60 mL/min.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 1) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 2) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 3) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 4) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 5) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 6) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 7) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 8) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 9) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 10) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA (LEVEL 11 UP-DOSE) - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA INITIAL (4-17 YRS) - CAPSULE, SPRINKLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALFORZIA LEVEL 11 MAINTENANCE - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Peanut Allergy. The member has a confirmed diagnosis of peanut allergy supported by both of the following: A clinical history of allergic reaction to peanuts AND A positive test for peanut specific-IgE or positive skin prick test.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALSONIFY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acromegaly: The member has a diagnosis of Acromegaly AND The member has had an inadequate response to pituitary surgery or pituitary surgery is not an option AND The member has tried or cannot use octreotide or lanreotide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PALYNZIQ - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Phenylketonuria. The member has a confirmed diagnosis of phenylketonuria as evidenced by elevated phenylalanine levels. Provider attests that member has undergone prior confirmatory testing consisting of: Plasma amino acid analysis which shows increased phenylalanine without increased tyrosine (increased phenylalanine:tyrosine ratio) AND A urine pterin analysis or red blood cell Dihydropteridine reductase (DHPR) assay showing no pterin defects or deficiency AND The member has documented uncontrolled baseline phenylalanine levels greater than 600 micromol/L on existing management (e.g., Kuvan (sapropterin), large amino acid therapy, phenylalanine restricted diet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PANRETIN - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	AIDS-related Kaposi's sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND systemic therapy is not required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PANZYGA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm³, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

PANZYGA - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

PARLODEL - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PAXIL - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

pazopanib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on previous pazopanib therapy.
Required Medical Information	Advanced Renal Cell Carcinoma RCC).The member has a diagnosis of advanced renal cell carcinoma (stage IV). First-line therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology OR as subsequent therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology in members who have progressed on prior first-line therapy.Soft Tissue Sarcoma. The member has a diagnosis of soft tissue sarcoma AND The member has progressed after prior chemotherapy. Thyroid Carcinoma: The member has a diagnosis of advanced or metastatic radio-iodine refractory follicular carcinoma, oncocytic cell carcinoma, papillary OR the member has a diagnosis of advanced medullary carcinoma and has disease progression on or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Ovarian Cancer. The member has a diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer. Uterine Neoplasms. The member has a diagnosis of stage II, III, IV, or advanced metastatic uterine neoplasm sarcoma and disease is not suitable for primary surgery AND Votrient (pazopanib) will be used as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PEDMARK - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cisplatin-Induced Ototoxicity - Pediatric: The member must have a localized, non-metastatic solid tumor AND the member must be receiving cisplatin-based therapy.
Age Restriction	The member must be 1 month of age or older but less than 18 years old.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PEGASYS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Hepatitis B - Adults: The member must have a diagnosis of chronic hepatitis B AND The member must have compensated liver disease AND The member must have evidence of viral replication AND The member must have evidence of liver inflammation AND The member must have had prior therapy, contraindication, or intolerance with both of the following: tenofovir disoproxil fumarate and entecavir. Chronic Hepatitis B - Pediatrics: The member must have a diagnosis of chronic hepatitis B AND The member must be non-cirrhotic AND The member must be HBeAg-positive AND The member must have evidence of viral replication AND The member must have elevations in serum alanine aminotransferase (ALT) AND the member must have had prior therapy, contraindication, or intolerance with both of the following: tenofovir disoproxil fumarate and entecavir. Chronic Hepatitis C - Adults: The member must have a diagnosis of chronic hepatitis C AND The member has compensated liver disease AND Pegasys (peginterferon alpha-2a) will be taken in combination with at least 1 other medication indicated for the treatment of chronic Hepatitis C AND the member has had previous treatment, contraindication, or intolerance to Epclusa.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 to 48 week treatment course depending on the disease state and/or genotype.
Other Criteria	Chronic Hepatitis C - Pediatrics: The member must have a diagnosis of chronic hepatitis C AND The member has compensated liver disease AND Pegasys (peginterferon alpha-2a) will be taken in combination with ribavirin AND the member has had previous treatment, contraindication, or intolerance to Epclusa.
Part B Prerequisite	0

PEMAZYRE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experienced disease progression on Pemazyre (pemigatinib)
Required Medical Information	Cholangiocarcinoma: The member has unresectable locally advanced or metastatic cholangiocarcinoma and the disease is fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test and the member has received prior treatment AND Pemazyre (pemigatinib) is given as a single agent for subsequent therapy. Relapsed or refractory myeloid/lymphoid neoplasms: the member has a diagnosis of relapsed or refractory myeloid/lymphoid neoplasms (MLNs) AND MLNs documented as fibroblast growth factor receptor 1 (FGFR1) rearrangement.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	
Part B Prerequisite	0

pemetrexed - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NSCLC (non-squamous): Squamous cell non-small cell lung cancer. Creatinine clearance (CrCl) less than 45 ml/minute. All other indications: Creatinine clearance (CrCl) less than 45 ml/minute.
Required Medical Information	Non-Small Cell Lung Cancer (Nonsquamous). The member has a diagnosis of non-squamous locally advanced or metastatic non-small cell lung cancer (NSCLC) AND One of the following applies: Pemetrexed will be used in combination with cisplatin or carboplatin therapy OR Pemetrexed will be used in a cisplatin or carboplatin-based regimen in combination with bevacizumab product OR Pemetrexed will be used as a single agent OR The member has no documented EGFR or ALK genomic tumor aberrations and pemetrexed will be given in combination with Keytruda (pembrolizumab) and carboplatin or cisplatin as first line therapy, followed by maintenance Keytruda (pembrolizumab) in combination with pemetrexed.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Malignant Pleural Mesothelioma. Diagnosis of malignant pleural mesothelioma.
Part B Prerequisite	0
PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NSCLC (non-squamous): Squamous cell non-small cell lung cancer. Creatinine clearance (CrCl) less than 45 ml/minute. All other indications: Creatinine clearance (CrCl) less than 45 ml/minute.

pemetrexed - VIAL (EA)

Required Medical Information	Non-Small Cell Lung Cancer (Nonsquamous). The member has a diagnosis of non-squamous locally advanced or metastatic non-small cell lung cancer (NSCLC) AND One of the following applies: Pemetrexed will be used in combination with cisplatin or carboplatin therapy OR Pemetrexed will be used in a cisplatin or carboplatin-based regimen in combination with bevacizumab product OR Pemetrexed will be used as a single agent OR The member has no documented EGFR or ALK genomic tumor aberrations and pemetrexed will be given in combination with Keytruda (pembrolizumab) and carboplatin or cisplatin as first line therapy, followed by maintenance Keytruda (pembrolizumab) in combination with pemetrexed.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Malignant Pleural Mesothelioma. Diagnosis of malignant pleural mesothelioma.
Part B Prerequisite	0

pemetrexed disodium - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NSCLC (non-squamous): Squamous cell non-small cell lung cancer. Creatinine clearance (CrCl) less than 45 ml/minute. All other indications: Creatinine clearance (CrCl) less than 45 ml/minute.
Required Medical Information	Non-Small Cell Lung Cancer (Nonsquamous). The member has a diagnosis of non-squamous locally advanced or metastatic non-small cell lung cancer (NSCLC) AND One of the following applies: Pemetrexed will be used in combination with cisplatin or carboplatin therapy OR Pemetrexed will be used in a cisplatin or carboplatin-based regimen in combination with bevacizumab product OR Pemetrexed will be used as a single agent OR The member has no documented EGFR or ALK genomic tumor aberrations and pemetrexed will be given in combination with Keytruda (pembrolizumab) and carboplatin or cisplatin as first line therapy, followed by maintenance Keytruda (pembrolizumab) in combination with pemetrexed.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Malignant Pleural Mesothelioma. Diagnosis of malignant pleural mesothelioma.
Part B Prerequisite	0

PEMRYDI RTU - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NSCLC (non-squamous): Squamous cell non-small cell lung cancer. Creatinine clearance (CrCl) less than 45 ml/minute. All other indications: Creatinine clearance (CrCl) less than 45 ml/minute.
Required Medical Information	Non-Small Cell Lung Cancer (Nonsquamous). The member has a diagnosis of non-squamous locally advanced or metastatic non-small cell lung cancer (NSCLC) AND One of the following applies: Pemetrexed will be used in combination with cisplatin or carboplatin therapy OR Pemetrexed will be used in a cisplatin or carboplatin-based regimen in combination with bevacizumab product OR Pemetrexed will be used as a single agent OR The member has no documented EGFR or ALK genomic tumor aberrations and pemetrexed will be given in combination with Keytruda (pembrolizumab) and carboplatin or cisplatin as first line therapy, followed by maintenance Keytruda (pembrolizumab) in combination with pemetrexed.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Malignant Pleural Mesothelioma. Diagnosis of malignant pleural mesothelioma.
Part B Prerequisite	0

penciclovir - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Recurrent herpes labialis (cold sores): Member has a diagnosis of recurrent herpes labialis (cold sores) AND the member has had previous treatment, contraindication, or intolerance with oral acyclovir and valacyclovir.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

penicillamine - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Wilson's Disease: The member has a diagnosis of Wilson's Disease confirmed by one of the following: presence of Kayser-Fleischer rings and low serum ceruloplasmin (CPN), molecular generic confirmation OR liver biopsy confirmation AND has had previous treatment or intolerance with generic penicillamine tablet. Cystinuria: The member has a diagnosis of cystinuria AND will be using in combination with all the following preventative measures unless there is a contraindication or intolerance to their use: high fluid intake (i.e. at least 2.5 liters daily), elevation of urine pH with potassium citrate and dietary modifications (i.e. limited sodium and protein intake) AND has previously been unresponsive to these preventative measures alone or has a contraindication or intolerance to their use AND has had previous treatment or intolerance with generic penicillamine tablet. Rheumatoid arthritis: The member has a diagnosis of rheumatoid arthritis AND has had previous treatment or intolerance with one of the following conventional treatments: hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine AND has had previous treatment or intolerance with generic penicillamine tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PENNSAID - SOLUTION IN METERED-DOSE PUMP (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Osteoarthritis. Member has a diagnosis of osteoarthritis of the knee(s).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

pepcid - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

perampanel - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: The member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate). Adjunctive treatment of generalized tonic-clonic seizures: The member has a diagnosis of generalized tonic-clonic seizures AND Member will use Fycompa (perampanel) in combination with at least one other drug for controlling seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling generalized tonic-clonic seizures (e.g. lamotrigine, topiramate, carbamazepine, gabapentin, divalproex).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PERCOCET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PERJETA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member exceeds a total treatment of 52 weeks or 18 treatment cycles (applicable to neoadjuvant and/or adjuvant treatment).
Required Medical Information	Metastatic Breast Cancer. The member has a diagnosis of metastatic breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND one of the following applies: will be receiving Perjeta (pertuzumab) in combination with trastuzumab product and docetaxel or paclitaxel and has not received prior anti-HER2 therapy or chemotherapy for metastatic disease OR The member will be receiving Perjeta (pertuzumab) in combination with a trastuzumab product with or without cytotoxic therapy as second or subsequent line therapy in members previously treated with chemotherapy and a trastuzumab product in the absence of prior Perjeta (pertuzumab). Early Stage Breast Cancer. The member has a diagnosis of locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) and HER2 positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND Perjeta (pertuzumab) will be used as neoadjuvant treatment as part of a complete treatment regimen and one of the following applies: in combination with trastuzumab product and docetaxel or paclitaxel (after completion of combination of doxorubicin plus cyclophosphamide regimen) or in combination with TCH (docetaxel, carboplatin, and trastuzumab product) OR The member has a diagnosis of early stage HER2 (e.g., defined as IHC 3+ or IHC2+/ISH positive) positive breast cancer at high risk of recurrence (e.g., node positive disease, hormone receptor negative, T2 non-metastatic disease) AND Perjeta (pertuzumab) will be used as adjuvant therapy and one of the following applies: combination with trastuzumab product and paclitaxel or docetaxel (following doxorubicin plus cyclophosphamide regimen) or docetaxel plus carboplatin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PHEBURANE - GRANULES (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Urea Cycle Disorders. The member has a diagnosis of urea cycle disorders (UCDs) AND the member will be using Pheburane in combination with a low protein diet AND the member has tried or cannot use a generic sodium phenylbutyrate product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PHESGO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member not to exceed a total treatment of 52 weeks or 18 treatment cycles (applicable to neoadjuvant and/or adjuvant therapy).
Required Medical Information	Early Stage Breast Cancer: The member has a diagnosis of locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) AND The member has documented HER2 (human epidermal growth factor receptor 2) positive disease AND Phesgo (pertuzumab, trastuzumab) will be used as neoadjuvant treatment as part of a complete treatment regimen AND one of the following applies: in combination with docetaxel, carboplatin in combination with docetaxel or paclitaxel (after completion of combination of doxorubicin plus cyclophosphamide regimen). The member has a diagnosis of early stage documented HER2 positive breast cancer at high risk of recurrence (e.g., node positive disease, hormone receptor negative, T2 non-metastatic disease) AND Phesgo (pertuzumab, trastuzumab) will be used as adjuvant therapy and one of the following applies: combination paclitaxel or docetaxel (following doxorubicin plus cyclophosphamide regimen) or docetaxel plus carboplatin. Metastatic Breast Cancer: The member has a diagnosis of metastatic breast cancer AND the member has documented HER2 (human epidermal growth factor receptor2) positive disease AND The member will be receiving Phesgo (pertuzumab, trastuzumab) in combination docetaxel or paclitaxel and has not received prior anti-HER2 therapy or chemotherapy for metastatic disease.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

PHYRAGO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on dasatinib. For ALL and CML: The member has one of the following mutations: T315I/A, F317L/V/I/C or V299L.
Required Medical Information	Chronic Myelogenous Leukemia (CML): The member has a diagnosis of Ph+ chronic myeloid leukemia (CML) and one of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated and one of the following applies: Intermediate- or high-risk score for disease progression OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib OR The member has a diagnosis of chronic phase CML that has received previous treatment AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. Acute Lymphoblastic Leukemia (ALL): The member has ALL (Philadelphia Chromosome positive) and dasatinib is being used for induction or consolidation treatment in combination with chemotherapy or corticosteroids OR treatment is for maintenance therapy or the treatment of members with resistance or intolerance to prior therapy AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. Advanced Gastrointestinal Stromal Tumor (GIST): The member has a diagnosis of advanced unresectable GIST. The member has progressive disease or is intolerant to prior therapy with imatinib or sunitinib or Stivarga (regorafenib) AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

PHYRAGO - TABLET

Other Criteria	[Pediatric] Chronic Myelogenous Leukemia (CML). The member has a diagnosis of chronic myeloid leukemia (CML) that is Philadelphia chromosome positive (Ph+) AND the member is in chronic phase AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. [Pediatric] Acute lymphoblastic leukemia (ALL). The member has a diagnosis of acute lymphoblastic leukemia (ALL) AND the member has Philadelphia chromosome positive (Ph+) disease AND the member has newly-diagnosed disease AND The member will be using dasatinib in combination with chemotherapy AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib.
Part B Prerequisite	0

PIASKY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH): The member's diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) has been determined by all the following: diagnosis was made by or in collaboration with a hematologist or PNH specialist AND peripheral blood flow cytometry testing has been performed AND flow cytometry results verify the presence of both: granulocyte PNH clones and Type II and/or Type III erythrocyte PNH clones AND one of the following applies to the member: the member has clinical signs of hemolysis (i.e., Lactate Dehydrogenase (LDH) greater than 1.5 x ULN or Absolute Reticulocyte Count (ARC) greater than 120 cells/ μ L) OR the member is transfusion dependent AND the member has clinical symptoms of PNH (e.g., fatigue, thromboembolic disease, dysphagia, odynophagia, abdominal pain, male impotence) AND The member weighs 40 kg or more.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

pimecrolimus - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Must have a diagnosis of atopic dermatitis and have had previous treatment with one of the following topical generic products: triamcinolone 0.025%, 0.1%, 0.5%, mometasone, betamethasone dipropionate. For Brand Elidel requests must have had previous treatment with pimecrolimus.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PIQRAY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members have severe hypersensitivity to Piqray (alpelisib). Members has experienced disease progression on PIK3CA inhibitors (e.g., alpelisib).
Required Medical Information	Breast Cancer: The member has a diagnosis of advanced or metastatic hormone receptor positive, human epidermal growth factor receptor 2 (HER 2) negative breast cancer and PIK3CA mutated as detected by FDA approved test AND the member has experienced disease progression on or after endocrine based therapy (e.g., aromatase inhibitor, cyclin-dependent kinase (CDK) 4/6 inhibitor) AND Piqray (alpelisib) will be given in combination with fulvestrant as subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

pirfenidone - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Idiopathic Pulmonary Fibrosis (IPF):The member meets ALL of the following criteria: Documentation of Pulmonary Fibrosis by one of the following: computed tomography (CT) scan that is indicative of usual interstitial pneumonia (UIP) OR surgical lung biopsy AND Has not had clinically significant environmental exposure or explanation for pulmonary fibrosis or interstitial lung disease (e.g. drugs, asbestos, beryllium, radiation, and domestic birds, radiation, sarcoidosis, hypersensitivity pneumonitis, bronchiolitis, obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, or cancer).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PLAQUENIL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PLAVIX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PLEGRIDY - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

plerixafor - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use beyond four consecutive days or use after completion of stem cell harvest/apheresis.
Required Medical Information	Autologous transplantation in patients with non-Hodgkin's Lymphoma (NHL) or Multiple Myeloma (MM): The member must have a diagnosis of non-Hodgkin's Lymphoma (NHL) or multiple myeloma (MM) AND Mozobil (plerixafor) must be used in combination with any GCSF (e.g., filgrastim, pegfilgrastim) or GM-CSF (e.g., sargramostim) AND Mozobil (plerixafor) must be a component of an autologous stem cell transplant mobilization protocol.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

POLIVY - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Diffuse large B-cell lymphoma - relapsed/refractory: Member has experienced disease progression on Polivy (polatuzumab vedotin-piiq). The member has active central nervous system lymphoma. The member has transformation from indolent lymphoma (e.g. follicular lymphoma) into diffuse large B-cell lymphoma. The member has received prior allogeneic hematopoietic stem cell transplant (HSCT). Diffuse large B-cell lymphoma - treatment-naive: The member has active central nervous system lymphoma. The member has transformation from indolent lymphoma (e.g. follicular lymphoma) into diffuse large B-cell lymphoma.
Required Medical Information	Diffuse large B-cell lymphoma - relapsed/refractory: the member has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma AND the member has received at least two prior lines of therapy AND the member will be using in combination with bendamustine and a rituximab product. Diffuse large B-cell lymphoma - treatment-naive: the member has a diagnosis of diffuse large B-cell lymphoma, not otherwise specified or high-grade B-cell lymphoma AND the member has not received previous treatment AND the member has a disease with a International Prognostic Index score of 2 or greater AND the member will be using Polivy (polatuzumab vedotin-piiq) in combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHOP).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

pomalidomide - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Pomalyst (pomalidomide).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of Multiple Myeloma AND The member has received at least two previous therapies AND The member has demonstrated disease progression while on Revlimid (lenalidomide) OR Thalomid (thalidomide) AND The member demonstrated disease progression while on a protease inhibitor (e.g. bortezomib, carfilzomib) AND The member demonstrated disease progression on or within 60 days of completion of the last therapy regimen [does not apply to requests for combination with Darzalex (daratumumab) plus dexamethasone or elotuzumab plus dexamethasone or Sarclisa (isatuximab) plus dexamethasone] AND The member will be using Pomalyst in one of the following regimens: in combination with dexamethasone and daratumumab, with dexamethasone and elotuzumab, with dexamethasone and ixazomib, with dexamethasone and cyclophosphamide, with dexamethasone, with dexamethasone and bortezomib, with dexamethasone and carfilzomib, dexamethasone and Sarclisa (isatuximab), dexamethasone and Xpovio (selinexor), or as a single agent (Omission of corticosteroid from regimen is allowed if intolerance/contraindication). Kaposi Sarcoma: The member has a diagnosis of AIDS-related Kaposi sarcoma after failure of highly active antiretroviral therapy OR The member has a diagnosis of Kaposi sarcoma that is HIV-negative.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

POMALYST - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Pomalyst (pomalidomide).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of Multiple Myeloma AND The member has received at least two previous therapies AND The member has demonstrated disease progression while on Revlimid (lenalidomide) OR Thalomid (thalidomide) AND The member demonstrated disease progression while on a protease inhibitor (e.g. bortezomib, carfilzomib) AND The member demonstrated disease progression on or within 60 days of completion of the last therapy regimen [does not apply to requests for combination with Darzalex (daratumumab) plus dexamethasone or elotuzumab plus dexamethasone or Sarclisa (isatuximab) plus dexamethasone] AND The member will be using Pomalyst in one of the following regimens: in combination with dexamethasone and daratumumab, with dexamethasone and elotuzumab, with dexamethasone and ixazomib, with dexamethasone and cyclophosphamide, with dexamethasone, with dexamethasone and bortezomib, with dexamethasone and carfilzomib, dexamethasone and Sarclisa (isatuximab), dexamethasone and Xpovio (selinexor), or as a single agent (Omission of corticosteroid from regimen is allowed if intolerance/contraindication). Kaposi Sarcoma: The member has a diagnosis of AIDS-related Kaposi sarcoma after failure of highly active antiretroviral therapy OR The member has a diagnosis of Kaposi sarcoma that is HIV-negative.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

POMBILITI - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Late Onset Pompe Disease. The member has a diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) AND The member weighs 40 kg or greater AND The member is not improving on current enzyme replacement therapy (ERT)(e.g. Nexviazyme (avalglucosidase alfa ngpt), Lumizyme (alglucosidase alfa)) AND The member is using Pombiliti in combination with Opfolda (Miglustat).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PONVORY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PONVORY 14-DAY STARTER PACK - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PORTRAZZA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Portrazza (necitumumab).
Required Medical Information	Non-Small Cell Lung Cancer: The member has a diagnosis of metastatic squamous non-small cell lung cancer AND The member will be initially using Portrazza (necitumumab) in combination with gemcitabine and cisplatin AND The member will be using Portrazza (necitumumab) as first-line treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

posaconazole - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis against Invasive Aspergillus and Candida Infections. The member must be using it for prophylaxis against invasive Aspergillus or Candida infections, and The member must be severely immunocompromised (such as hematopoietic stem cell transplant recipient with graft-vs-host disease, or neutropenic patients with acute myelogenous leukemia (AML) or myelodysplastic syndromes (MDS).Treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes. The member must have documentation for treatment of invasive Aspergillus or fungal infections caused by Fusarium and/or Zygomycetes, and The member must have documented resistant strains of or clinically refractory to standard antifungal agents (e.g. voriconazole, itraconazole) or those who can not receive other antifungal agents due to potential toxicities, intolerance, or contraindications. Treatment of Esophageal Candidiasis. The member must have a diagnosis for esophageal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole. Treatment of Oropharyngeal Candidiasis (Suspension only). The member must have a diagnosis for oropharyngeal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

POTELIGEO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member has experienced disease progression while on or following Poteligeo (mogamulizumab-kpkc).
Required Medical Information	Mycosis fungoides or Sézary syndrome: The member has a diagnosis of mycosis fungoides or Sézary syndrome AND The member has relapsed or refractory disease AND The member will be using Poteligeo (mogamulizumab-kpkc) as the sole systemic therapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	NA
Part B Prerequisite	0

PRADAXA - PELLETS IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Venous thromboembolism (VTE): The member has a diagnosis of VTE and has been treated with a parenteral anticoagulant for at least 5 days OR the member has a history of VTE and has been previously treated AND the member has had prior therapy, contraindication, or intolerance to Xarelto (rivaroxaban) oral suspension, Eliquis (apixaban) sprinkle capsule, OR Eliquis (apixaban) tablet for oral suspension.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

pralatrexate - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on pralatrexate.
Required Medical Information	Peripheral T-cell Lymphoma(PTCL):relapsed or refractory. Pralatrexate is being used to treat relapsed or refractory peripheral T-cell lymphoma (PTCL) (eg peripheral T-cell lymphoma, not otherwise specified: angioimmunoblastic T-cell lymphoma, anaplastic large cell lymphoma or enteropathy-associated T-cell lymphoma.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PRALUENT PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Homozygous Familial Hypercholesterolemia (HoFH): diagnosis of homozygous familial hypercholesterolemia AND LDL-C is currently greater than 70mg/dL despite treatment on maximally tolerated combination lipid lowering therapy (e.g. statins, ezetimibe, Repatha) AND previous treatment, intolerance, or contraindication to Repatha (evolocumab).
Age Restriction	Hypercholesterolemia: Member must be 8 years of age or older. Cardiovascular Event Prevention: Member must be 18 years of age or older. Homozygous familial hypercholesterolemia: Member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

PRALUENT PEN - PEN INJECTOR (ML)

Other Criteria	Cardiovascular Event Prevention: The member must have an increased risk of major adverse cardiovascular events (e.g., acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin) AND Praluent (alirocumab) is used as adjunctive therapy to maximally tolerated high-intensity statin (e.g., atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMS) defined by one of the following: SAMS symptoms included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMS despite both lowering of statin strength in combination with ezetimibe AND Attempting a different statin in combination with ezetimibe OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects AND Member has had previous treatment with contraindication or intolerance with Repatha (evolucumab). Hypercholesterolemia: Diagnosis of hypercholesterolemia (Note: Includes heterozygous familial hypercholesterolemia [HeFH], pure hypercholesterolemia, and mixed hyperlipidemia) AND Praluent (alirocumab) is used as adjunctive therapy to maximally tolerated high intensity statin (e.g., atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMS) defined by one of the following: SAMS symptoms include rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMS despite both lowering of statin strength in combination with ezetimibe AND attempting a different statin in combination with ezetimibe OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects AND The member must have previous treatment with, contraindication, or intolerance with Repatha.
Part B Prerequisite	0

prednisone - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rayos is being used as an anti-inflammatory or immunosuppressive agent for certain allergic, dermatologic, gastrointestinal, hematologic, ophthalmologic, nervous system, renal, respiratory, rheumatologic, specific infectious diseases or conditions and organ transplantation OR for the treatment of certain endocrine conditions OR for palliation of certain neoplastic conditions AND the member must have had previous treatment with prednisone immediate-release, and at least one other generically available corticosteroid (e.g.dexamethasone, methylprednisolone, prednisolone).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

pregabalin - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neuropathic pain associated with diabetic peripheral neuropathy (DPN). The member must have a diagnosis of diabetic peripheral neuropathy. The member has had previous treatment with at least two of the following: gabapentin, duloxetine, lidocaine 5% topical patch, pregabalin (immediate release). Post-Herpetic Neuralgia (PHN). The member must have a diagnosis of post-herpetic neuralgia. The member has had previous treatment with at least two of the following: gabapentin, lidocaine 5% topical patch, pregabalin (immediate release).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PREGNYL - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Obesity, Female or male infertility, Erectile Dysfunction, Precocious puberty, Prostatic carcinoma or other androgen-dependent neoplasm.
Required Medical Information	NA
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

PREVACID - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PREVYMIS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis (PPX) of CMV Infection and Disease in CMV Seropositive Recipients [R+] of an Allogeneic Hematopoietic Stem Cell Transplant (HSCT). Member must have received an allogeneic hematopoietic stem cell transplant. Member must be CMV-seropositive [R+]. Member must weigh at least 6 kg. Prevymis (letermovir) must be initiated within 28 days post-transplant. Prophylaxis (PPX) of CMV disease in kidney transplant recipients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-]). Member must have received a kidney transplant AND Member must be CMV-seronegative (R-) AND Member must have received a kidney from a CMV-seropositive (D+) donor AND Member must weigh at least 40 kg AND Member must have a medical reason as to why valganciclovir therapy cannot be started or continued (e.g., breakthrough CMV infection, adverse effects leading to discontinuation of valganciclovir).
Age Restriction	Prophylaxis of CMV Infection and Disease in CMV Seropositive Recipients [R+] of an Allogeneic Hematopoietic Stem Cell Transplant (HSCT): The member must be at least 6 months of age or older. Prophylaxis of CMV disease in kidney transplant recipients at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-]): The member must be at least 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 Months Duration
Other Criteria	
Part B Prerequisite	0

PRIALT - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Pre-existing history of psychosis. Contraindications to IT analgesia including: The presence of infection at the microinfusion injection site, Uncontrolled bleeding diathesis, Spinal canal obstruction.
Required Medical Information	Severe chronic pain: Intrathecal therapy for the treatment of severe chronic pain is warranted. Member must be intolerant of or refractory to other treatment, such as systemic analgesics, adjunctive therapies, or intrathecal (IT) morphine. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

primlev - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Pain: Has pain severe enough to require an opioid pain medication and for which alternative treatments are inadequate AND Has had previous treatment, contraindication, or intolerance to BOTH of the following: hydrocodone-325mg acetaminophen tablet (e.g., generic Norco) AND oxycodone-325mg acetaminophen tablet (e.g., generic Percocet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PRISTIQ - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PRIVIGEN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

PRIVIGEN - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/ thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

PROCARDIA XL - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PROCRIT - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Anemia of CKD: Diagnosis of anemia associated with chronic kidney disease. Hgb level less than 10.0 g/dL or HCT less than 30- within last 4 weeks. Continue Therapy: Current- within last 4 weeks Hgb level less than 11 g/dL OR documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Anemia in Zidovudine-treated HIV-infected: Diagnosed with HIV (and AZT induced anemia) and receiving zidovudine treatment corresponding with HAART. Endogenous serum erythropoietin levels less than or equal to 500 mUnits/mL. The total zidovudine dose must not exceed 4200mg/wk. Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30-within the last four weeks. Continue Therapy: Zidovudine dose must not exceed 4200mg/wk. Must meet one of the following criteria: Current-within last 4 weeks Hgb level less than 12.0 g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia in Chemotherapy Treated Cancer - first 4 weeks. Diagnosis with a non-myeloid, non-erythroid malignancy. Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than 10.0 g/dL or HCT less than 30-within last 4 weeks. Maint. Phase after first 4 weeks: Member has responded to therapy, defined as one or more of the following: increase in hemoglobin of at least 1 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements OR prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level sufficient to avoid RBC transfusion.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan year duration. Reauth: Plan year duration.

PROCRIT - VIAL (ML)

Other Criteria	Anemia in Surgery Members: Must be scheduled to undergo elective, noncardiac, nonvascular surgery. Must have Hgb level of greater than 10 g/dL and less than or equal 13 g/dL (within last 4 weeks). Anemia in Myelodysplastic Syndromes: symptomatic anemia associated with MDS. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL (unlikely to respond to ESA therapy if erythropoietin level greater than 500mUnits/ml). Must have Hgb level less than 12 g/dL or HCT less than 30 (within last 4 weeks). Cont. Therapy: has responded to therapy, defined as one or more of the following: An increase in hemoglobin of at least 1.5 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements, OR prescriber determines to continue therapy. Cont. dosing is needed to maintain the lowest hemoglobin level (not to exceed 12 g/dL) sufficient to avoid RBC transfusion. Anemia associated with Management of Hepatitis C: anemia in management of chronic Hepatitis C. Receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have Hgb level less than or equal to 12.0 gm/dL or HCT less than 30 during combination therapy as defined above(within the last 4 weeks).Continue Therapy: Must be receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV.Must have been able to maintain previous ribavirin dosing without dose reduction due to symptomatic anemia. Must meet one of the following criteria: Current (within the last 4 weeks) Hgb level less than 12.0g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia associated with Rheumatoid Arthritis (RA) Treatment. Diagnosis of anemia associated with pharmaceutical treatment of RA. Receiving active therapy known to cause anemia. Must have Hgb level less than 10 g/dL or HCT less than 30(within the last 4 weeks).Cont. Therapy: Receiving active RA pharmaceutical treatment. Current (within the last 4 weeks) Hgb less than 11 g/dL. For listed indications: Prior to initiation of therapy, other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Prior to initiation of therapy, the member's iron scores should be evaluated. Transferrin saturation should be at least 20% OR ferritin at least 100 ng/mL within the last 4 months (applies to most recent result). Cont. of therapy requires documented Transferrin saturation of at least 20% OR ferritin of at least 100 ng/mL within the last 4 months for all indications (applies to most recent result). Must have an inadequate response to Retacrit therapy for at least 2 consecutive months with appropriate dose adjustment.
Part B Prerequisite	0

PROCYSBI - GRANULES, DELAYED RELEASE, IN PACKET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cystinosis: The member has a diagnosis of nephropathic cystinosis and the member has previous treatment failure or intolerance with Cystagon (cysteamine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PROGLYCEM - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PROLASTIN-C - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	IgA deficient members or presence of antibodies against IgA.
Required Medical Information	The member must meet ALL of the following criteria: Diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed AND Has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or PI (null, null) or phenotypes associated with reduced serum alpha-1 antitrypsin concentrations, AND an initial serum alpha 1-antitrypsin concentration of less than 57mg/dL when measured by nephelometry OR less than 80 mg/dL when measured by radial immunodiffusion. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema.) For requests for Prolastin-C, Glassia and Aralast-NP: The member must have prior therapy with, intolerance to, or contraindication to Zemaira.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PROLATE - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Pain: Has pain severe enough to require an opioid pain medication and for which alternative treatments are inadequate AND Has had previous treatment, contraindication, or intolerance to BOTH of the following: hydrocodone-325mg acetaminophen tablet (e.g., generic Norco) AND oxycodone-325mg acetaminophen tablet (e.g., generic Percocet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PROMACTA - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	ITP members with previous documented failure of eltrombopag.
Required Medical Information	Persistent or Chronic Immune Thrombocytopenic Purpura. Initial Approval: The member has a diagnosis of persistent or chronic immune thrombocytopenic purpura (minimum 3-month disease history) AND The member has a platelet count of less than 50 x 109/L. The member has had documented failure, intolerance, or contraindication to at least one course of prednisone or dexamethasone OR The member has had a splenectomy. Reauthorizations: The member has a platelet count of less than 400 x 109/L. Thrombocytopenia in Patients with Hepatitis C Infection: Initial Approval: The member has a diagnosis of chronic hepatitis C. The member has a platelet count of less than 75 x 109/L. One of the following applies: Is attempting to initiate and maintain interferon based therapy OR is currently receiving interferon based therapy. Reauthorization: The member has a platelet count of less than 400 x 109/L AND The member continues to receive interferon based therapy. Aplastic Anemia: Initial Approval: The member has a diagnosis of aplastic anemia AND The member will receive Promacta (eltrombopag) in combination with immunosuppressive therapy (e.g. cyclosporine, antithymocyte immune globulin) for first-line treatment of severe aplastic anemia OR Promacta (eltrombopag) is being used for the treatment of refractory severe aplastic anemia in members with an insufficient response to immunosuppressive therapy (e.g. cyclosporine, antithymocyte immune globulin). Reauthorization: The member has a platelet count of less than 400 x 109/L.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

PROSCAR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PROTONIX - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PROVIGIL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Excessive Daytime Sleepiness.For the treatment of excessive daytime sleepiness or hypersomnolence associated with Narcolepsy,obstructive sleep apnea,or due to sleep problems resulting from circadian rhythm disruption (i.e., shift-work sleep disorder). For Brand Name only: The member must also have had previous treatment, intolerance, or contraindication to armodafinil or modafinil. Steinert myotonic dystrophy syndrome. Member must have hypersomnia due to Steinert myotonic dystrophy syndrome. For Brand Name only: The member must also have had previous treatment, intolerance, or contraindication to modafinil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PROZAC - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

prucalopride - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Idiopathic Constipation: The member must have a diagnosis of chronic idiopathic constipation AND the member has had previous treatment, intolerance, or contraindication to Linzess (linaclotide) and lubiprostone.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PRUDOXIN - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of atopic dermatitis or lichen simplex chronicus AND the member has had previous treatment with, contraindication, or intolerance to at least two of the following topical products: triamcinolone, mometasone, fluticasone cream, betamethasone, or clobetasol cream/ointment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

pruradik - LOTION (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Scabies. Member must have a diagnosis of scabies AND Has had previous treatment, contraindication or intolerance to permethrin 5% cream AND oral ivermectin. Pruritic Skin. Member must be using to treat pruritis of the skin AND Has had previous treatment, contraindication, or intolerance to a topical corticosteroid (e.g. hydrocortisone, triamcinolone, mometasone) AND an oral antihistamine (e.g. hydroxyzine, levocetirizine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

pyquvi - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Duchenne Muscular Dystrophy: The member must have a diagnosis of Duchenne Muscular Dystrophy confirmed by dystrophin genetic testing AND the member has onset of muscle weakness before 5 years of age AND the member has had previous treatment of prednisone for at least 6 months and experienced one of the following: undesirable weight gain defined as more than 20% of body weight gain increase from baseline that required prednisone dose reduction OR a severe behavioral adverse effect (e.g., unmanageable irritation, aggression) that required prednisone dose reduction.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PYRUKYND - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hemolytic Anemia: the member has a diagnosis of pyruvate kinase deficiency with at least two mutant alleles in the PKLR gene, of which at least one is missense mutation. The member is not homozygous for the R479H mutation or had two non-missense, variants, without the presence of another missense variant in the PKLR gene. The member had a hemoglobin level less than or equal to 10g/dL.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PYZCHIVA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PYZCHIVA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohns disease AND the member has had prior therapy, contraindication, or intolerance with Remicade OR Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

PYZCHIVA AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

QALSODY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis with SOD1 mutation (SOD1-ALS) - Initial criteria: Member has a diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) as determined by a provider who specializes in the treatment of ALS (e.g. neurologist, neuromuscular specialist) AND Member has a confirmed mutation in the superoxide dismutase 1 (SOD1) gene AND Documentation (e.g. chart notes, genetic testing results) must be submitted AND Member has elevated plasma (serum) neurofilament light chain (NfL) at baseline (i.e. above the lab reference range) AND Documentation (e.g. chart notes, lab results) must be submitted AND Member is able to independently perform all or some activities of daily living (ADLs) AND Member does not have a tracheostomy or require invasive ventilation AND Member is also being treated with riluzole OR has previously tried and cannot use riluzole. Amyotrophic Lateral Sclerosis with SOD1 mutation (SOD1-ALS) - Reauthorization criteria: Member's plasma (serum) neurofilament light chain (NfL) has decreased from or remained below baseline (i.e. compared to the member's pre-treatment NfL value) AND Documentation (e.g. chart notes, lab results) must be submitted AND Member continues to be able to independently perform all or some activities of daily living (ADLs) AND Member remains independent of tracheostomy or invasive ventilation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

QBREXZA - TOWELETTE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hyperhidrosis: Member has a diagnosis of primary axillary hyperhidrosis of at least a 6 month duration AND has documentation of Hyperhidrosis Disease Severity Scale (HDSS) rating of 3 or 4 AND has had previous treatment with, intolerance or contraindication to at least one conventional treatment (e.g. aluminum chloride 20% antiperspirant, oral oxybutynin).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

QELBREE - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD): The member must have a diagnosis of attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD) AND The member has had previous treatment with, contraindication, or intolerance to the following: A stimulant medication (e.g. methylphenidate, dextroamphetamine-amphetamine) or non-stimulant medication (e.g. guanfacine ER, clonidine) AND atomoxetine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

QINLOCK - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Gastrointestinal Stromal Tumor (GIST): The member has a diagnosis of advanced GIST AND The member has received prior therapy with three or more kinase inhibitors, including imatinib AND Qinlock (ripretinib) is being used as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

QIVIGY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

QIVIGY - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

QTERN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus. Member must have diagnosis of Type 2 Diabetes Mellitus and member must have previous treatment with, contraindication, or intolerance to the following therapies: One of the following DPP-4 inhibitors: sitagliptin OR linagliptin OR One of the following SGLT2 inhibitors: empagliflozin OR dapagliflozin OR One of the following SGLT2 inhibitor/DPP-4 inhibitor combination drugs: Glyxambi (empagliflozin and linagliptin) OR Trijardy XR (linagliptin, empagliflozin, metformin).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

QUDEXY XR - CAPSULE SPRINKLE, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention: The member is using topiramate ER capsule (e.g., Trokendi XR, Qudexy XR) for prophylaxis (prevention) of migraine headache AND the member has had previous treatment with immediate release topiramate AND has had previous treatment, intolerance, or contraindication with one of the following: a serotonin and norepinephrine reuptake inhibitor or a tricyclic antidepressant. Epilepsy Adjunct Therapy: Member has a diagnosis of partial-onset (focal) seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS) AND Member will use topiramate ER capsule (e.g., Trokendi XR, Qudexy XR) in combination with at least one other drug for controlling seizures AND member has tried or cannot use immediate-release topiramate tablet or capsule. Epilepsy Monotherapy: Member has a diagnosis of partial-onset (focal) seizures or primary generalized tonic-clonic seizures AND member has tried or cannot use immediate-release topiramate tablet or capsule.
Age Restriction	Migraine - 12 years of age or older, Seizures - Trokendi XR: 6 years of age or older. Seizures - Qudexy XR: 2 years of age or older.
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

quinine sulfate - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Prolongation of QT interval. Myasthenia gravis. Optic neuritis.
Required Medical Information	Plasmodium Falciparum Malaria: Diagnosis of uncomplicated chloroquine-resistant Plasmodium falciparum malaria. Brand Qualaquin request only: Members must have had previous treatment with generic Qualaquin (Quinine) or who have had contraindications or intolerance with generic Qualaquin (Quinine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

QULIPTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention: Will be utilizing Qulipta (atogepant) for the preventative treatment of migraines.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

QUTENZA - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-herpetic Neuralgia: The member must have a diagnosis of neuropathic pain associated with post- herpetic neuralgia AND the member has a trial, intolerance or contraindicated to two drugs from the anticonvulsant (e.g. gabapentin or pregabalin) and/or tri-cyclic antidepressant class (e.g., nortriptyline or desipramine). Diabetic Peripheral Neuropathy (PHN): Has a diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet AND has had previous treatment with at least TWO of the following: gabapentin, duloxetine, lidocaine 5% topical patch, pregabalin (immediate release).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RADICAVA - INTRAVENOUS SOLUTION, PIGGYBACK (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): Member has a diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) as determined by a provider who specializes in the treatment of ALS (e.g. neurologist, neuromuscular specialist) AND Member has a baseline score of 2 points or greater for each individual item on the ALS Functional Rating Scale-Revised (ALSFRS-R) AND Member is able to independently perform all or some activities of daily living (ADLs) when therapy is started AND Member has a disease duration of 2 years or less when therapy is started AND Member is also being treated with riluzole OR has previously tried and cannot use riluzole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RADICAVA ORS - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): Member has a diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) as determined by a provider who specializes in the treatment of ALS (e.g. neurologist, neuromuscular specialist) AND Member has a baseline score of 2 points or greater for each individual item on the ALS Functional Rating Scale-Revised (ALSFRS-R) AND Member is able to independently perform all or some activities of daily living (ADLs) when therapy is started AND Member has a disease duration of 2 years or less when therapy is started AND Member is also being treated with riluzole OR has previously tried and cannot use riluzole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RADICAVA ORS STARTER KIT SUSP - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): Member has a diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) as determined by a provider who specializes in the treatment of ALS (e.g. neurologist, neuromuscular specialist) AND Member has a baseline score of 2 points or greater for each individual item on the ALS Functional Rating Scale-Revised (ALSFRS-R) AND Member is able to independently perform all or some activities of daily living (ADLs) when therapy is started AND Member has a disease duration of 2 years or less when therapy is started AND Member is also being treated with riluzole OR has previously tried and cannot use riluzole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RAGWITEK - TABLET, SUBLINGUAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Allergic Rhinitis with or without Conjunctivitis. Member must have a diagnosis of allergic rhinitis with or without conjunctivitis. Diagnosis has been confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the species contained in the product. Member must have been unable to achieve adequate symptom control with a nasal corticosteroid (e.g. fluticasone) AND a nasal antihistamine (e.g. azelastine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

RAPAFLO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RASUVO (PF) - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis (RA): The member has a diagnosis of severe active rheumatoid arthritis AND the member has previous treatment or intolerance with generic methotrexate. Polyarticular Juvenile Idiopathic Arthritis (pJIA): The member has a diagnosis of active pJIA AND the member has previous treatment or intolerance with generic methotrexate. Psoriasis: The member has a diagnosis of active severe, recalcitrant, disabling psoriasis AND the member has previous treatment or intolerance with generic methotrexate.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RAVICTI - LIQUID (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Treatment of N-acetylglutamate synthetase (NAGS) deficiency.
Required Medical Information	Urea Cycle Disorders. The member has a diagnosis of urea cycle disorders (UCDs) AND the member will be using Ravicti in combination with a low protein diet AND the member has tried or cannot use a sodium phenylbutyrate product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RAYOS - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rayos is being used as an anti-inflammatory or immunosuppressive agent for certain allergic, dermatologic, gastrointestinal, hematologic, ophthalmologic, nervous system, renal, respiratory, rheumatologic, specific infectious diseases or conditions and organ transplantation OR for the treatment of certain endocrine conditions OR for palliation of certain neoplastic conditions AND the member must have had previous treatment with prednisone immediate-release, and at least one other generically available corticosteroid (e.g.dexamethasone, methylprednisolone, prednisolone).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REBIF (WITH ALBUMIN) - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REBIF REBIDOSE - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REBIF TITRATION PACK - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REBLOZYL - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Beta-Thalassemia. Member has a diagnosis of transfusion-dependent Beta-thalassemia AND Member does not have a diagnosis of S/B+ thalassemia (Sickle, Beta Thalassemia), or Alpha thalassemia. Myelodysplastic syndromes (MDS) associated anemia: Member has a diagnosis of Myelodysplastic Syndrome or myelodysplastic/myeloproliferative neoplasms (MDS/MPN) related anemia AND the member has a documented very-low to intermediate risk disease as defined by IPSS-R risk score AND the member does not have a deletion 5q mutation AND One of the following: Ring sideroblasts (RS) positive (RS greater than or equal to 15% or RS greater than or equal to 5% with an SF3B1 mutation) OR RS negative (RS less than 15% or RS less than 5% with an SF3B1 mutation) and serum EPO less than or equal to 500mU/mL and the member is unresponsive or intolerant to ESAs (e.g., Retacrit, Procrit) AND Member is not receiving Reblozyl in combination with ESA treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

REBYOTA - ENEMA (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prevention of Recurrence of Clostridioides difficile Infection: The member has a positive stool test within the last 30 days for Clostridioides difficile with the capability to produce toxins (e.g. polymerase chain reaction, or enzyme immunoassay) AND The member has experienced at least 2 recurrent Clostridioides difficile infections (CDI) (i.e. 3 or more CDI episodes) AND The member has completed a full course of antibiotic therapy (e.g. oral vancomycin or fidaxomicin) for the most recent CDI episode AND The member's current CDI episode must be controlled (i.e. reduced stool frequency) AND The member will receive Rebyota within 24 to 72 hours of completion of the antibiotic course
Age Restriction	The member is 18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RECLAST - IV SOLUTION, PIGGYBACK, BOTTLE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Osteoporosis: The member has a diagnosis of osteoporosis. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance to any other oral bisphosphonate. Osteoporosis Prophylaxis in postmenopausal members: The member is postmenopausal. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance to any other oral bisphosphonate. Glucocorticoid induced Osteoporosis in men and women taking systemic glucocorticoids: Diagnosis of glucocorticoid induced osteoporosis or is either initiating or continuing systemic glucocorticoids with a daily dosage equivalent of 7.5 mg or greater of prednisone and is expected to remain on glucocorticoids for at least 12 months AND has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance to any other oral bisphosphonate . Paget's Disease: Diagnosis of Paget's disease. The member has continued elevation(s) in serum alkaline phosphatase (SAP) of two times or higher than the upper limit of normal despite previous treatment, contraindication, or intolerance to any other oral bisphosphonate. And the member: Is symptomatic OR is at risk for complications from their disease, to induce remission, or to normalize serum alkaline phosphatase. Brand Reclast request only: Members must have previous treatment, contraindication, or intolerance to generic Zoledronic acid (generic Reclast).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RECORLEV - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cushing's Syndrome: The member has a diagnosis of Cushing's syndrome AND the member is not a candidate for surgery or surgery has not been curative AND the member has had previous treatment, contraindication, or intolerance to oral ketoconazole. (Documentation or rationale to why the contraindication or intolerance to oral ketoconazole is not expected to apply to levoketoconazole therapy is required).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REDEMPLO - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Familial Chylomicronemia Syndrome (FCS): The member has fasting triglyceride levels greater than or equal to 880 mg/dL prior to Redemplo (plozasiran) initiation AND The member has a diagnosis of familial chylomicronemia syndrome as defined by at least one of the following: Genetic confirmation demonstrating biallelic pathogenic variants in at least one gene causing FCS: lipoprotein lipase (LPL), apolipoprotein C-II (ApoC2), glycosylphosphatidylinositol-anchored high-density lipoprotein-binding protein 1 (GPIHBP1), apolipoprotein A-V (ApoA5), or lipase maturation factor 1 (LMF1) OR North American FCS score of greater than or equal to 45 OR Familial chylomicronemia syndrome score greater than or equal to 10 OR History of acute pancreatitis OR History of recurrent, unexplained abdominal pain. The member is on a low-fat diet (less than or equal to 20 g fat per day) AND The member is treated by or in consultation with a specialist (e.g. cardiologist, endocrinologist).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

REGRANEX - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Known neoplasm at the site of application.
Required Medical Information	Member must be using for the treatment of lower extremity diabetic ulcers AND the ulcer extends into the subcutaneous tissue or beyond AND the ulcer has an adequate blood supply AND Regranex will be used in combination with good ulcer care practices including debridement, pressure relief and prevention and treatment of infection.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

RELEUKO - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member had previous treatment or intolerance to both of the following: Zarxio (filgrastim-sndz) and Nivestym (filgrastim-aafi) AND Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

RELEUKO - SYRINGE (ML)

Other Criteria	The member must have previous treatment with or intolerance to both of the the following: Zarxio (filgrastim-sndz) and Nivestym (filgrastim-aafi): Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following progenitor-cell transplantation. The member must have had a peripheral-blood progenitor cell (PBPC) transplantation for a non-myeloid malignancy AND The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML). The member must be receiving either induction chemotherapy OR consolidation chemotherapy The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Harvesting of peripheral blood stem cells: The member is using as a component of a hematopoietic stem cell mobilization protocol and one of the following applies: is scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, is storing cells for a possible future autologous transplant, or is donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic: The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia. Neutropenia in Myelodysplastic Syndromes: The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia: The member must have a diagnosis of febrile neutropenia. Filgrastim must be used in adjunct with appropriate antibiotics in high risk patients. Neutropenia in AIDS patients: The member must have a diagnosis of AIDS with neutropenia. Treatment of Aplastic Anemia: The member must have a diagnosis of Aplastic Anemia. Treatment of Agranulocytosis: The member must have a diagnosis of congenital or drug induced agranulocytosis. Hematopoietic Syndrome of Acute radiation syndrome: The member has been acutely exposed to myelosuppressive doses of radiation.
Part B Prerequisite	0

RELISTOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Opioid-induced constipation (OIC) in adult members with chronic non-cancer pain: Member has a diagnosis of opioid-induced constipation AND Member has taken an opioid agonist for at least 4 weeks for non-cancer pain, including pain related to prior cancer or its treatment that does not require frequent (e.g., weekly) opioid dose increases AND The member must have had previous treatment, intolerance, or contraindication to lubiprostone AND Movantik (naloxegol). Opioid-induced constipation in members with advanced illness receiving palliative care after failing laxative therapy (injection formulation only): Member has opioid induced constipation AND Member has advanced illness or pain caused by active cancer AND Is receiving opioids for palliative care AND The member must have had previous treatment, intolerance, or contraindication to Lactulose.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RELTONE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Gallstone Treatment: Member is using Reltone (ursodiol) to treat radiolucent, noncalcified gallstones AND has had previous treatment or intolerance with generic ursodiol tablets or 300 mg capsules. Gallstone Prevention: Member is using Reltone (ursodiol) to prevent gallstone formation during rapid weight loss AND has had previous treatment or intolerance with generic ursodiol tablets or 300 mg capsules.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REMICADE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Combination therapy with other biologics (e.g. Cosentyx, Enbrel, adalimumab product, Kevzara, Remicade).
Required Medical Information	Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs and must be on concomitant treatment with methotrexate during therapy, unless contraindicated or intolerant to methotrexate. Crohn's Disease (Non-Fistulizing) and Ulcerative Colitis: Diagnosis of moderate to severely active Crohn's disease OR moderately to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance with a corticosteroid (e.g. prednisone, hydrocortisone, methylprednisolone) OR 5-aminosalicylic acids (e.g. mesalamine, osalazine) OR immunomodulator (e.g. azathioprine or 6-mercaptopurine). Ankylosing Spondylitis: Diagnosis of highly persistent, active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with at least one non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen).
Age Restriction	Must be 18 years of age for Plaque Psoriasis, Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Fistulizing Crohn's Disease. Must be 6 years of age for Crohn's Disease (Non-Fistulizing) and Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

REMICADE - VIAL (EA)

Other Criteria	Psoriatic arthritis: Diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, meloxicam, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. sulfasalazine, methotrexate, leflunomide) or contraindication to all DMARDs. Plaque Psoriasis: Diagnosis of moderate to severe, extensive chronic plaque psoriasis. The member has had prior therapy with or intolerance to conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine) or contraindication to all conventional oral systemic treatments. Fistulizing Crohn's Disease: The member must have a diagnosis of Crohn's disease with one or more draining fistulas AND The member has had prior therapy, contraindication, or intolerance with one or more immunosuppressive agents (e.g. azathioprine, 6 mercaptopurine)
Part B Prerequisite	0

REMODULIN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND WHO Functional Class II-IV AND Pulmonary hypertension has progressed despite maximal medical and/or surgical treatment AND Member experiences significant symptoms (e.g. dyspnea on exertion, fatigue, angina, syncope) AND Treatment with oral calcium channel blockers has been tried and failed or has been considered and ruled out. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RENFLEXIS - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Combination therapy with other biologics (e.g. Cosentyx, Enbrel, adalimumab product, Kevzara, Remicade).
Required Medical Information	Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis AND the member must be on concomitant treatment with methotrexate during therapy, unless contraindicated or intolerant to methotrexate AND the member has failed to achieve symptom control (e.g. reduced joint pain, reduced joint swelling) or has intolerance with one of the following: Remicade, Inflectra, unbranded infliximab, or Simponi Aria. Fistulizing Crohn's Disease: Diagnosis of Crohn's disease with one or more draining fistulas. The member has had prior therapy, contraindication, or intolerance with one or more immunosuppressive agents (e.g. azathioprine, 6-mercaptopurine). The member has failed to achieve symptom control (e.g. improved liquid or soft stool, reduced abdominal pain, stable weight) or has intolerance with Remicade OR Inflectra OR unbranded infliximab. Crohn's Disease (non-fistulizing) and Ulcerative Colitis - Adult: Diagnosis of moderate to severely active Crohn's disease or moderate to severely active ulcerative colitis. The member has failed to achieve symptom control (e.g. improved liquid or soft stool, reduced abdominal pain, stable weight) or has intolerance with: Remicade OR Inflectra OR unbranded infliximab, AND the member has had prior therapy, contraindication, or intolerance with a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Ankylosing Spondylitis: Diagnosis of highly persistent, active ankylosing spondylitis. Member has failed to achieve symptoms control (e.g. reduced spinal pain, reduced inflammation) or has intolerance with one of the following: Remicade, Inflectra, unbranded infliximab or Simponi Aria.
Age Restriction	Must be 18 years of age for Plaque Psoriasis, Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Fistulizing Crohn's Disease. Must be 6 years of age for Crohn's Disease (Non-Fistulizing) and Ulcerative Colitis.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

RENFLEXIS - VIAL (EA)

Other Criteria	Psoriatic arthritis: Diagnosis of active psoriatic arthritis AND one of the following criteria are met: the member has failed to achieve symptom control (e.g. reduced joint pain or swelling, reduced erythema) or has intolerance with Remicade, Inflectra, unbranded infliximab OR Simponi Aria, AND The member has had prior therapy, contraindication or intolerance with a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek). Plaque Psoriasis: Diagnosis of moderate to severe, extensive chronic plaque psoriasis. The member has failed to achieve symptom control (e.g. reduction in erythema, reduction of area of skin involved) or has intolerance with Remicade, Inflectra, OR unbranded infliximab. The member has had prior therapy, contraindication or intolerance with a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek). Crohns disease and Ulcerative Colitis - pediatrics: Diagnosis of moderately to severely active Crohns disease or moderately to severely active ulcerative colitis. The member has failed to achieve symptom control (e.g. reduced stool frequency, reduced rectal bleeding) or has intolerance with Remicade or Inflectra or unbranded infliximab.
Part B Prerequisite	0

REPATHA PUSHTRONEX - WEARABLE INJECTOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hypercholesterolemia: Diagnosis of hypercholesterolemia (Note: includes heterozygous familial hypercholesterolemia [HeFH], pure hypercholesterolemia, and mixed hyperlipidemia) AND Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) defined by any of the following: Statin associated rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMs despite lowering of statin strength AND attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects.
Age Restriction	Hypercholesterolemia: Member must be 10 years of age or older. Cardiovascular Event Prevention: Member must be 18 years of age or older. Homozygous familial hypercholesterolemia: Member must be 10 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Cardiovascular Event Prevention: The member must have an increased risk of major adverse cardiovascular events (e.g. acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin) AND Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) defined by any of the following: Statin associated rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite lowering of statin strength and attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of HoFH AND Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.

REPATHA PUSHTRONEX - WEARABLE INJECTOR

Part B Prerequisite	0

REPATHA SURECLICK - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hypercholesterolemia: Diagnosis of hypercholesterolemia (Note: includes heterozygous familial hypercholesterolemia [HeFH], pure hypercholesterolemia, and mixed hyperlipidemia) AND Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) defined by any of the following: Statin associated rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMs despite lowering of statin strength AND attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects.
Age Restriction	Hypercholesterolemia: Member must be 10 years of age or older. Cardiovascular Event Prevention: Member must be 18 years of age or older. Homozygous familial hypercholesterolemia: Member must be 10 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Cardiovascular Event Prevention: The member must have an increased risk of major adverse cardiovascular events (e.g. acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin) AND Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) defined by any of the following: Statin associated rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite lowering of statin strength and attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of HoFH AND Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.

REPATHA SURECLICK - PEN INJECTOR (ML)

Part B Prerequisite	0

REPATHA SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hypercholesterolemia: Diagnosis of hypercholesterolemia (Note: includes heterozygous familial hypercholesterolemia [HeFH], pure hypercholesterolemia, and mixed hyperlipidemia) AND Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to have statin-associated muscle symptoms (SAMs) defined by any of the following: Statin associated rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of SAMs despite lowering of statin strength AND attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects.
Age Restriction	Hypercholesterolemia: Member must be 10 years of age or older. Cardiovascular Event Prevention: Member must be 18 years of age or older. Homozygous familial hypercholesterolemia: Member must be 10 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Cardiovascular Event Prevention: The member must have an increased risk of major adverse cardiovascular events (e.g. acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin) AND Repatha (evolocumab) is used as adjunctive therapy in members taking maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) and have failed to achieve goal LDL-C OR the member is determined to have statin-associated muscle symptoms (SAMs) defined by any of the following: Statin associated rhabdomyolysis OR member has failed to achieve goal LDL-C reduction because of SAMs despite lowering of statin strength and attempting a different statin OR provider attestation that statin use has been tried and failed and is not clinically appropriate due to intolerable adverse effects. Homozygous Familial Hypercholesterolemia (HoFH): The member must have a diagnosis of HoFH AND Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.

REPATHA SYRINGE - SYRINGE (ML)

Part B Prerequisite	0

RESTASIS - DROPPERETTE, SINGLE-USE DROP DISPENSER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dry eye disease. Has a diagnosis of dry eye disease AND has had previous treatment, contraindication, or intolerance to the following: cyclosporine eye drops (generic Restasis), AND Eysuvis (loteprednol)*. *Previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RESTASIS MULTIDOSE - DROPS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dry eye disease. Has a diagnosis of dry eye disease AND has had previous treatment, contraindication, or intolerance to the following: cyclosporine eye drops (generic Restasis), AND Eysuvis (loteprednol)*. *Previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RESTORIL - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RETACRIT - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Anemia of CKD: Diagnosis of anemia associated with chronic kidney disease. Hgb level less than 10.0 g/dL or HCT less than 30- within last 4 weeks. Continue Therapy: Current- within last 4 weeks Hgb level less than 11 g/dL OR documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Anemia in Zidovudine-treated HIV-infected: Diagnosed with HIV (and AZT induced anemia) and receiving zidovudine treatment corresponding with HAART. Endogenous serum erythropoietin levels less than or equal to 500 mUnits/mL. The total zidovudine dose must not exceed 4200mg/wk. Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30-within the last four weeks. Continue Therapy: Zidovudine dose must not exceed 4200mg/wk. Must meet one of the following criteria: Current-within last 4 weeks Hgb level less than 12.0 g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia in Chemotherapy Treated Cancer - first 4 weeks. Diagnosis with a non-myeloid, non-erythroid malignancy. Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than 10.0 g/dL or HCT less than 30-within last 4 weeks. Maint. Phase after first 4 weeks: Member has responded to therapy, defined as one or more of the following: increase in hemoglobin of at least 1 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements OR prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level sufficient to avoid RBC transfusion.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: Plan year duration. Reauth: Plan year duration.

RETACRIT - VIAL (ML)

Other Criteria	Anemia in Surgery Members: Must be scheduled to undergo elective, noncardiac, nonvascular surgery. Must have Hgb level of greater than 10 g/dL and less than or equal 13 g/dL (within last 4 weeks). Anemia in Myelodysplastic Syndromes: Diagnosis of symptomatic anemia associated with MDS. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL (unlikely to respond to ESA therapy if erythropoietin level greater than 500mUnits/ml). Must have Hgb level less than 12 g/dL or HCT less than 30 (within last 4 weeks). Continue Therapy: The member has responded to therapy, defined as one or more of the following: An increase in hemoglobin of at least 1.5 g/dL OR An increase in hemoglobin to greater than or equal to 10 g/dL OR a decrease in red blood cell (RBC) transfusion requirements, OR prescriber determines to continue therapy. Continued dosing is needed to maintain the lowest hemoglobin level (not to exceed 12 g/dL) sufficient to avoid RBC transfusion. Anemia associated with Management of Hepatitis C. Diagnosis of anemia in management of chronic Hepatitis C. Receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have Hgb level less than or equal to 12.0 gm/dL or HCT less than 30 during combination therapy as defined above (within the last 4 weeks). Continue Therapy: Must be receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have been able to maintain previous ribavirin dosing without dose reduction due to symptomatic anemia. Must meet one of the following criteria: Current (within the last 4 weeks) Hgb level less than 12.0g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia associated with Rheumatoid Arthritis (RA) Treatment. Diagnosis of anemia associated with pharmaceutical treatment of RA. Receiving active therapy known to cause anemia. Must have Hgb level less than 10 g/dL or HCT less than 30 (within the last 4 weeks). Continue Therapy: Receiving active RA pharmaceutical treatment. Current (within the last 4 weeks) Hgb less than 11 g/dL. For listed indications: Prior to initiation of therapy, other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Prior to initiation of therapy, the member's iron scores should be evaluated. Transferrin saturation should be at least 20% OR ferritin at least 100 ng/mL within the last 4 months (applies to most recent result). Continuation of therapy requires documented Transferrin saturation of at least 20% OR ferritin of at least 100 ng/ mL within the last 4 months for all indications (applies to most recent result).
Part B Prerequisite	0

RETEVMO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Retevmo
Required Medical Information	Non-small cell lung cancer. The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer AND The disease is documented RET fusion positive AND Retevmo is being used as monotherapy. Medullary Thyroid cancer. The member has a diagnosis of metastatic or advanced medullary thyroid cancer AND The disease is documented RET mutant AND Retevmo is being used as a single agent for systemic therapy. Thyroid cancer. The member has a diagnosis of metastatic or advanced thyroid cancer AND The disease is documented RET fusion positive AND The disease is radioactive iodine refractory (if radioactive iodine is appropriate) AND Retevmo is being used as a single agent for systemic therapy. RET fusion-positive Solid Tumors: the member has locally advanced or metastatic solid tumors AND the solid tumors have documented rearranged during transfection (RET) gene fusion positive AND the member has progressed on or following prior systemic treatment or has no satisfactory alternative treatment options AND Retevmo (selpercatinib) is being administered as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

RETIN-A - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RETIN-A MICRO - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RETIN-A MICRO PUMP - GEL WITH PUMP (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REVATIO - SUSPENSION, RECONSTITUTED, ORAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. The member has had prior therapy, contraindication, or intolerance to a phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g., sildenafil or tadalafil).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REVATIO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension(PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. For brand Revatio requests only: The member has had prior therapy, contraindication, or intolerance to generic sildenafil (Revatio) tablet OR generic tadalafil (Adcirca) tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REVCovi - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Adenosine deaminase severe combined immune deficiency (ADA-SCID): The member has a diagnosis of adenosine deaminase severe combined immune deficiency.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

REVLIMID - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on lenalidomide.
Required Medical Information	For brand Revlimid requests: Member must have an intolerance or contraindication to generic lenalidomide AND member must meet clinical criteria below. Myelodysplastic Syndromes (MDS) with 5Q deletion. The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has a documented deletion 5q chromosomal abnormality AND the member has one of the following: Symptomatic Anemia (e.g. chronic fatigue, malaise) OR Transfusion-dependent anemia OR Anemia that is not controlled with erythroid stimulating agent. Myelodysplastic Syndromes (MDS) without 5Q deletion (non-5Q deletion). The member has a diagnosis of low- or intermediate-1 risk myelodysplastic syndrome (MDS) AND the member has no documented 5q deletion abnormality AND the member has one of the following: Symptomatic Anemia (e.g. chronic fatigue, malaise) OR Transfusion-dependent anemia OR Anemia that is not controlled with erythroid stimulating agent. Multiple Myeloma. Diagnosis of active Multiple Myeloma or Systemic Light Chain Amyloidosis. Primary induction OR for relapsed/refractory disease, lenalidomide therapy should be utilized in conjunction with dexamethasone if no contraindication. As maintenance therapy in patients with multiple myeloma following autologous hematopoietic stem cell transplantation. Chronic Lymphoid Leukemia. Diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration

REVLIMID - CAPSULE

Other Criteria	For brand Revlimid requests: Member must have an intolerance or contraindication to generic lenalidomide AND member must meet clinical criteria below. Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND The member has relapsed or refractory disease AND The member will be using for third line or subsequent systemic therapy. Non-Hodgkin Lymphoma: The member has one of the following diagnoses: AIDS-related B-cell lymphoma, diffuse large B-cell lymphoma, mucosa-associated lymphoid tissue (MALT) lymphoma [either gastric or nongastric], marginal zone lymphoma, or mantle cell lymphoma AND The member has relapsed or refractory disease OR The member has a diagnosis of follicular lymphoma AND The member will use as first line therapy or for relapsed or refractory disease.
Part B Prerequisite	0

REVUFORJ - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following a menin inhibitor (e.g., Revuforj (revumenib), Komzifti (ziftomenib)).
Required Medical Information	Acute Leukemia: The member has a diagnosis of acute leukemia AND the member has relapsed or refractory disease AND One of the following: the member has documented lysine methyltransferase 2A (KMT2A) mutation as determined by an FDA authorized test OR the member has acute myeloid leukemia with a susceptible nucleophosmin 1 (NPM1) mutation and there are no satisfactory alternative treatment options.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

REXULTI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Major depressive disorder: The member has a clinical diagnosis of major depressive disorder (MDD) AND The member must have documentation of prior therapy, intolerance, or contraindication to at least one generic oral atypical antipsychotic therapy AND Rexulti (brexpiprazole) must be used as adjunctive (add-on) treatment to antidepressant therapy and not as monotherapy. Schizophrenia: The member must have clinically diagnosed schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to one generic oral atypical antipsychotic therapy. Agitation Associated with Dementia Due to Alzheimer's Disease: The member must have clinically diagnosed agitation associated with dementia due to Alzheimer's disease AND Rexulti (brexpiprazole) will not be used as an as needed (prn) treatment for agitation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REYVOW - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Migraine. The member will be utilizing Reyvow (lasmiditan) for the acute treatment of migraines. AND The member has had previous treatment, intolerance, or contraindication to Ubrelvy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REZDIFFRA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Metabolic dysfunction-associated steatohepatitis (MASH) [formerly known as nonalcoholic steatohepatitis (NASH)]: Member has a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) [formerly known as nonalcoholic steatohepatitis (NASH)] confirmed by at least one of the following: Liver biopsy, Vibration-Controlled transient elastography (VCTE), or Magnetic resonance elastography (MRE) AND Member has moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) AND Provider attests member will use Rezdiffra in combination with diet and exercise AND Prescribed by or in consultation with a specialist with experience treating MASH/NASH (e.g., hepatologist, gastroenterologist) AND Member has at least one metabolic risk factors (e.g., hypertriglyceridemia, raised fasting plasma glucose, central obesity).
Age Restriction	The member is at least 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

REZLIDHIA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on or following Rezlidhia (olutasidenib).
Required Medical Information	Acute Myeloid Leukemia - Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member has a documented IDH1 mutation AND The member will be using Rezlidhia (olutasidenib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

REZUROCK - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Rezurock (belumosudil).
Required Medical Information	Chronic Graft Versus Host Disease (cGVHD): The member has a diagnosis of chronic graft vs host disease (cGVHD) AND the member has been unable to achieve treatment goals with at least two prior lines of systemic therapy AND the member has a medical reason as to why Jakafi (ruxolitinib) cannot be started or continued.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

REZVOGLAR KWIKPEN - INSULIN PEN (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of type 1 or type 2 diabetes mellitus AND The member has had previous treatment or intolerance with at least one preferred insulin glargine product: Lantus, Lantus Solostar OR Toujeo AND insulin degludec (i.e. Tresiba).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

REZZAYO - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Candidemia. The member has a diagnosis of candidemia AND The member has had prior therapy, contraindication, or intolerance to one of the following: caspofungin or micafungin. Invasive Candidiasis. The member has a diagnosis of invasive candidiasis AND The member has had prior therapy, contraindication, or intolerance to one of the following: caspofungin or micafungin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

RHAPSIDO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Spontaneous Urticaria (CSU): Has a diagnosis of chronic spontaneous urticaria AND Has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy, unless contraindicated AND Will continue to receive H1 antihistamine therapy while on Rhapsido, unless contraindicated AND Has had previous treatment, contraindication, or intolerance to Dupixent (dupilumab).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RIABNI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Chronic Lymphocytic Leukemia: High dose CLL therapies (doses greater than 500mg/m²). The length of maintenance therapy exceeds 2 years for chronic lymphocytic leukemia. Non-Hodgkin's Lymphoma (CD-20 positive/B-cell): The member will be using rituximab as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma). Waldenstrom's Macroglobulinemia: The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).
Required Medical Information	For requests for Rituxan or Truxima: member must have intolerance or contraindication with Ruxience or Riabni and meet the criteria below. Chronic Lymphocytic Leukemia. The member has a diagnosis of CLL. Non-Hodgkin's Lymphoma (CD-20 positive/B-Cell). The member has a diagnosis of CD-20 positive/B-cell Non-Hodgkin's lymphoma. Hodgkin's Disease (Hodgkin's Lymphoma). The member has a diagnosis of Hodgkin's Disease. The member will be using rituximab product for primary treatment or for relapsed or progressive disease AND disease has confirmed CD20 positivity. Rheumatoid Arthritis. The member has a diagnosis of moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with, contraindication, or intolerance with one of the following: Remicade, Inflectra, infliximab, or Simponi Aria* (previous treatment with Simponi Aria applies to medical benefit requests only). The member must be on concomitant treatment with methotrexate during rituximab product therapy, unless contraindicated or intolerant to methotrexate.
Age Restriction	Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

RIABNI - VIAL (ML)

Other Criteria	Waldenström's macroglobulinemia. The member must have a diagnosis of Waldenström's macroglobulinemia. Post-transplant lymphoproliferative disorder. The member has a diagnosis of Post-transplant Lymphoproliferative disease. Immune or Idiopathic Thrombocytopenic Purpura. The member must have a diagnosis of refractory primary immune or idiopathic thrombocytopenic purpura. Member has not had a splenectomy, but has had an insufficient response or is intolerant to corticosteroids, AND immunoglobulins (IVIG), OR has had a splenectomy with an inadequate response or is intolerant to procedure AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Refractory response is characterized as EITHER: Platelet count less than 25,000/microliter OR Active bleeding due to inadequate platelet function. The member must have had an inadequate response to post-splenectomy corticosteroid therapy for four consecutive weeks within the last three months. Diagnosis of Wegener's Granulomatosis OR Microscopic Polyangiitis. Must be taking rituximab product in combination with glucocorticoids. Pemphigus Vulgaris (PV). The member must have a diagnosis of moderate to severe Pemphigus Vulgaris.
Part B Prerequisite	0

RIDAURA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must have a diagnosis of active rheumatoid arthritis AND must have had prior therapy, contraindication or intolerance with a nonsteroidal anti-inflammatory drug (e.g. meloxicam, celecoxib) AND a conventional disease-modifying antirheumatic drug (e.g. methotrexate, leflunomide, sulfasalazine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RINVOQ - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis: The member has a diagnosis of moderate to severely active rheumatoid arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz, Enbrel). Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz, Enbrel). Atopic Dermatitis: The member has a diagnosis of moderate to severe atopic dermatitis AND the member has had prior therapy, contraindication or intolerance with at least one other systemic therapy. Ulcerative Colitis: the member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz) or at least one approved systemic therapy if a TNF blocker cannot be used. Ankylosing Spondylitis: the member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz, Enbrel). Non-radiographic Axial Spondylarthritis: the member has a diagnosis of non-radiographic axial spondylarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance to one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz, Enbrel). Crohn's Disease: the member has a diagnosis of moderately to severely active crohn's disease AND the member has had prior therapy, contraindication, or intolerance with one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz) or at least one approved systemic therapy if a TNF blocker cannot be used.
Age Restriction	RA, UC, ankylosing spondylitis, Non-radiographic axial spondylarthritis, Giant Cell Arteritis and Crohn's Disease: The member is 18 years of age or older. Atopic Dermatitis: the member is 12 years of age or older. Psoriatic arthritis and polyarticular juvenile idiopathic arthritis: the member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

RINVOQ - TABLET, EXTENDED RELEASE 24 HR

Other Criteria	Polyarticular Juvenile Idiopathic Arthritis: The member has a diagnosis of active polyarticular juvenile idiopathic arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz, Enbrel). Giant Cell Arteritis: the member has a diagnosis of giant cell arteritis.
Part B Prerequisite	0

RINVOQ LQ - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz, Enbrel). Polyarticular Juvenile Idiopathic Arthritis: The member has a diagnosis of active polyarticular juvenile idiopathic arthritis AND the member has had prior therapy, contraindication or intolerance with one or more TNF blockers (e.g. Humira, adalimumab-adbm, adalimumab-adaz, Enbrel).
Age Restriction	The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RITALIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RITALIN LA - CAPSULE,EXTENDED RELEASE BIPHASIC 50-50

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RITUXAN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Chronic Lymphocytic Leukemia: High dose CLL therapies (doses greater than 500mg/m²). The length of maintenance therapy exceeds 2 years for chronic lymphocytic leukemia. Non-Hodgkin's Lymphoma (CD-20 positive/B-cell): The member will be using rituximab as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma). Waldenstrom's Macroglobulinemia: The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).
Required Medical Information	For requests for Rituxan or Truxima: member must have intolerance or contraindication with Ruxience or Riabni and meet the criteria below. Chronic Lymphocytic Leukemia. The member has a diagnosis of CLL. Non-Hodgkin's Lymphoma (CD-20 positive/B-Cell). The member has a diagnosis of CD-20 positive/B-cell Non-Hodgkin's lymphoma. Hodgkin's Disease (Hodgkin's Lymphoma). The member has a diagnosis of Hodgkin's Disease. The member will be using rituximab product for primary treatment or for relapsed or progressive disease AND disease has confirmed CD20 positivity. Rheumatoid Arthritis. The member has a diagnosis of moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with, contraindication, or intolerance with one of the following: Remicade, Inflectra, infliximab, or Simponi Aria* (previous treatment with Simponi Aria applies to medical benefit requests only). The member must be on concomitant treatment with methotrexate during rituximab product therapy, unless contraindicated or intolerant to methotrexate.
Age Restriction	Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

RITUXAN - VIAL (ML)

Other Criteria	Waldenström's macroglobulinemia. The member must have a diagnosis of Waldenström's macroglobulinemia. Post-transplant lymphoproliferative disorder. The member has a diagnosis of Post-transplant Lymphoproliferative disease. Immune or Idiopathic Thrombocytopenic Purpura. The member must have a diagnosis of refractory primary immune or idiopathic thrombocytopenic purpura. Member has not had a splenectomy, but has had an insufficient response or is intolerant to corticosteroids, AND immunoglobulins (IVIG), OR has had a splenectomy with an inadequate response or is intolerant to procedure AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Refractory response is characterized as EITHER: Platelet count less than 25,000/microliter OR Active bleeding due to inadequate platelet function. The member must have had an inadequate response to post-splenectomy corticosteroid therapy for four consecutive weeks within the last three months. Diagnosis of Wegener's Granulomatosis OR Microscopic Polyangiitis. Must be taking rituximab product in combination with glucocorticoids. Pemphigus Vulgaris (PV). The member must have a diagnosis of moderate to severe Pemphigus Vulgaris.
Part B Prerequisite	0

RITUXAN HYCELA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member will be using Rituxan Hycela (rituximab/hyaluronidase) for the treatment of a non-malignant condition (e.g. rheumatoid arthritis). The member will be using Rituxan Hycela (rituximab/hyaluronidase) as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The member will be using Rituxan Hycela (rituximab/hyaluronidase) as a single agent for first-line therapy in follicular lymphoma (FL). The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma). The length of maintenance therapy exceeds 2 years for chronic lymphocytic leukemia.
Required Medical Information	For requests for Rituxan Hycela: member has a medical reason as to why Ruxience or Riabni cannot be started or continued and meets the criteria below. Chronic Lymphocytic Leukemia: The member must have a diagnosis of chronic lymphocytic leukemia AND The member will be using Rituxan Hycela as monotherapy or in combination with fludarabine and cyclophosphamide. Follicular lymphoma: The member has a diagnosis of follicular lymphoma AND One of the following applies: Previously untreated disease and will be using Rituxan Hycela in combination with first line chemotherapy and, in patients achieving a complete or partial response to Rituxan Hycela in combination with chemotherapy, as single-agent maintenance therapy OR Non-progressing (including stable disease) disease, as a single agent after first line cyclophosphamide, vincristine, and prednisone chemotherapy OR Relapsed or refractory disease, as a single agent. Diffuse large B cell lymphoma: The member has a diagnosis of diffuse large B cell lymphoma AND The member has previously untreated disease and will be using Rituxan Hycela in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone or with another anthracycline-based chemotherapy regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RIVFLOZA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Hyperoxaluria Type 1 (PH1) (Initial): Member has a diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by one of the following: Genetic testing showing biallelic pathogenic variants in AGXT OR Identification of AGT enzyme deficiency on liver biopsy AND Has elevated oxalate levels (e.g. urine oxalate excretion greater than 0.5 mmol (or 45mg)/1.73 m² /day, urinary oxalate:creatinine ratio above the laboratory's age- specific reference range, or plasma oxalate level greater than 2 micromol/L) AND Prescribed by or in consultation with a nephrologist, urologist, geneticist, or other provider with experience managing primary hyperoxaluria AND Has not received a liver transplant. Primary Hyperoxaluria Type 1 (PH1) (Continuation): The member has had a clinical response to Rivfloza therapy as demonstrated by one of the following: Reduced urinary or plasma oxalate levels from initiation of Rivfloza OR Reduced urinary oxalate/creatinine ratio from initiation of Rivfloza AND Has not received a liver transplant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: 6 months duration. Continuation: Plan year duration.
Other Criteria	
Part B Prerequisite	0

ROBINUL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ROBINUL FORTE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ROLVEDON - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND The member must have a diagnosis of non-myeloid malignancy (e.g. Solid Tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.

ROLVEDON - SYRINGE (ML)

Part B Prerequisite	0

romidepsin - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on romidepsin.
Required Medical Information	Cutaneous T-cell Lymphoma (CTCL). Istodax (romidepsin) is being used to treat cutaneous T-cell lymphoma AND one of the following applies: the member will be using Istodax (romidepsin) as primary biologic systemic therapy OR the member has received at least one prior therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ROMVIMZA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Symptomatic Tenosynovial Giant Cell Tumor: Member has symptomatic tenosynovial giant cell tumor (TGCT) AND Surgical resection will potentially cause worsening functional limitation or severe morbidity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ROXICODONE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ROXYBOND - TABLET, ORAL ONLY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute or Chronic Pain: Has pain severe enough to require an opioid pain medication and for which alternative treatments are inadequate AND Has had previous treatment, contraindication, or intolerance to at least TWO of the following immediate-release opioids: oxycodone (non-abuse deterrent formulation), hydromorphone, OR morphine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ROZLYTREK - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) AND the member has disease which is ROS1-positive. Solid Tumors: the member has a diagnosis of solid tumors which are metastatic OR The member is not a candidate for surgical resection AND The member has a documented neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation AND The member's disease has progressed following treatment or does not have satisfactory alternative therapy options.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RUBRACA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula(niraparib)].
Required Medical Information	Epithelial Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer Maintenance Therapy: The member has a diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member has deleterious BRCA mutation (germline and/or somatic) AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Rubraca (rucaparib) as monotherapy* AND *Discontinue Bevacizumab product before initiating maintenance therapy with Rubraca. Metastatic Castration-Resistant Prostate Cancer: The member has a diagnosis metastatic castration-resistant prostate cancer (mCRPC) AND The member has documented deleterious BRCA mutation (germline and/or somatic) AND The member has had prior treatment with androgen receptor-directed therapy (e.g. abiraterone, Xtandi, Erleada, or Nubeqa) AND The member will use Rubraca (rucaparib) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RUCONEST - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE): The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member is using Ruconest for the treatment of acute attacks of HAE. The member has had previous treatment, contraindication, or intolerance to generic icatibant. Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response, member's contraindication to generic icatibant, OR describing the side effects observed with generic icatibant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

rufinamide - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients with familial short QT syndrome.
Required Medical Information	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND Banzel (rufinamide) will be used in combination with at least one other drug for controlling seizures AND The member has been unable to achieve seizure control with at least one other drug used for the adjunctive treatment of Lennox-Gastaut syndrome (e.g., lamotrigine, topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RUXIENCE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Chronic Lymphocytic Leukemia: High dose CLL therapies (doses greater than 500mg/m²). The length of maintenance therapy exceeds 2 years for chronic lymphocytic leukemia. Non-Hodgkin's Lymphoma (CD-20 positive/B-cell): The member will be using rituximab as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma). Waldenstrom's Macroglobulinemia: The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).
Required Medical Information	For requests for Rituxan or Truxima: member must have intolerance or contraindication with Ruxience or Riabni and meet the criteria below. Chronic Lymphocytic Leukemia. The member has a diagnosis of CLL. Non-Hodgkin's Lymphoma (CD-20 positive/B-Cell). The member has a diagnosis of CD-20 positive/B-cell Non-Hodgkin's lymphoma. Hodgkin's Disease (Hodgkin's Lymphoma). The member has a diagnosis of Hodgkin's Disease. The member will be using rituximab product for primary treatment or for relapsed or progressive disease AND disease has confirmed CD20 positivity. Rheumatoid Arthritis. The member has a diagnosis of moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with, contraindication, or intolerance with one of the following: Remicade, Inflectra, infliximab, or Simponi Aria* (previous treatment with Simponi Aria applies to medical benefit requests only). The member must be on concomitant treatment with methotrexate during rituximab product therapy, unless contraindicated or intolerant to methotrexate.
Age Restriction	Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

RUXIENCE - VIAL (ML)

Other Criteria	Waldenström's macroglobulinemia. The member must have a diagnosis of Waldenström's macroglobulinemia. Post-transplant lymphoproliferative disorder. The member has a diagnosis of Post-transplant Lymphoproliferative disease. Immune or Idiopathic Thrombocytopenic Purpura. The member must have a diagnosis of refractory primary immune or idiopathic thrombocytopenic purpura. Member has not had a splenectomy, but has had an insufficient response or is intolerant to corticosteroids, AND immunoglobulins (IVIG), OR has had a splenectomy with an inadequate response or is intolerant to procedure AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Refractory response is characterized as EITHER: Platelet count less than 25,000/microliter OR Active bleeding due to inadequate platelet function. The member must have had an inadequate response to post-splenectomy corticosteroid therapy for four consecutive weeks within the last three months. Diagnosis of Wegener's Granulomatosis OR Microscopic Polyangiitis. Must be taking rituximab product in combination with glucocorticoids. Pemphigus Vulgaris (PV). The member must have a diagnosis of moderate to severe Pemphigus Vulgaris.
Part B Prerequisite	0

RYBELSUS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using for weight loss.
Required Medical Information	Diabetes Mellitus. The member has a diagnosis of type 2 diabetes mellitus.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RYBREVANT - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members who have disease progression on an amivantamab product (does not apply to NSCLC EGFR Exon 19 Deletion or Exon 21 L858R Mutated [Lazcluze (lazertinib) Combination]).
Required Medical Information	Non-small cell lung cancer (NSCLC) [Monotherapy]: The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The NSCLC has documented epidermal growth factor receptor (EGFR) exon 20 insertion mutations (e.g. as detected by a FDA-approved test) AND the member has documented disease progression on prior platinum-based chemotherapy AND The amivantamab product (i.e., Rybrevant, Rybrevant Faspro) will be given as monotherapy. Non-small cell lung cancer (NSCLC) [Combination Therapy]: The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The NSCLC has documented epidermal growth factor receptor (EGFR) exon 20 insertion mutations (e.g. as detected by a FDA-approved test) AND The amivantamab product will be given in combination with carboplatin and pemetrexed in the first line setting. NSCLC EGFR Exon 19 Deletion or Exon 21 L858R Mutated [Lazcluze (lazertinib) Combination]: The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The NSCLC has documented epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations AND The amivantamab product will be given in combination with Lazcluze (lazertinib) in the first-line setting or as subsequent therapy (if not previously given). NSCLC EGFR Exon 19 Deletion or Exon 21 L858R Mutated [Other Combination Therapy]: The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The NSCLC has documented epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations AND The member has experienced disease progression on or after an EGFR tyrosine kinase inhibitor [e.g. Tagrisso (osimertinib)] AND The amivantamab product will be given in combination with carboplatin and pemetrexed as subsequent line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

RYBREVANT - VIAL (ML)

Part B Prerequisite	0

RYBREVANT FASPRO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members who have disease progression on an amivantamab product (does not apply to NSCLC EGFR Exon 19 Deletion or Exon 21 L858R Mutated [Lazcluze (lazertinib) Combination]).
Required Medical Information	Non-small cell lung cancer (NSCLC) [Monotherapy]: The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The NSCLC has documented epidermal growth factor receptor (EGFR) exon 20 insertion mutations (e.g. as detected by a FDA-approved test) AND the member has documented disease progression on prior platinum-based chemotherapy AND The amivantamab product (i.e., Rybrevant, Rybrevant Faspro) will be given as monotherapy. Non-small cell lung cancer (NSCLC) [Combination Therapy]: The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The NSCLC has documented epidermal growth factor receptor (EGFR) exon 20 insertion mutations (e.g. as detected by a FDA-approved test) AND The amivantamab product will be given in combination with carboplatin and pemetrexed in the first line setting. NSCLC EGFR Exon 19 Deletion or Exon 21 L858R Mutated [Lazcluze (lazertinib) Combination]: The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The NSCLC has documented epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations AND The amivantamab product will be given in combination with Lazcluze (lazertinib) in the first-line setting or as subsequent therapy (if not previously given). NSCLC EGFR Exon 19 Deletion or Exon 21 L858R Mutated [Other Combination Therapy]: The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The NSCLC has documented epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations AND The member has experienced disease progression on or after an EGFR tyrosine kinase inhibitor [e.g. Tagrisso (osimertinib)] AND The amivantamab product will be given in combination with carboplatin and pemetrexed as subsequent line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	

RYBREVANT FASPRO - VIAL (ML)

Part B Prerequisite	0

RYDAPT - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	AML newly diagnosed: Members that are using Rydapt(midostaurin) for post-consolidation therapy. AML relapsed/refractory: Members that have experienced disease progression while on or following Rydapt (midostaurin), Members that are using Rydapt(midostaurin) for post-consolidation therapy. Systemic Mastocytosis: Members that have experienced disease progression while on or following Rydapt (midostaurin).
Required Medical Information	Acute Myeloid Leukemia-Newly diagnosed: The member has newly diagnosed acute myeloid leukemia (AML) AND The member has documented FLT3 mutation-positive disease AND The member will be using Rydapt (midostaurin) in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Systemic Mastocytosis: The member has a diagnosis of aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematologic neoplasm (SM-AHN), or mast cell leukemia (MCL). Acute Myeloid Leukemia - Relapsed/Refractory: The member has relapsed or refractory acute myeloid leukemia (AML) AND The member has documented FLT3 mutation-positive disease AND The member will be using Rydapt (midostaurin) as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

RYLAZE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with a history of serious pancreatitis with prior asparaginase based therapy. Members with a history of serious thrombosis with prior asparaginase based therapy. Members with a history of serious hemorrhagic events with prior asparaginase based therapy. Members that have experienced disease progression while on asparaginase based therapy.
Required Medical Information	Acute Lymphoblastic Leukemia (ALL) or Lymphoblastic Lymphoma (LBL): The member has a diagnosis of acute lymphoblastic leukemia (ALL) or Lymphoblastic lymphoma (LBL) AND The member has documented, Grade 2 - 4 hypersensitivity (based on Common Terminology Toxicity Criteria) as a result of prior treatment with Oncaspar (pegaspargase) AND The member is using Rylaze (asparaginase Erwinia chrysanthemi-rywn) as a component of a multi-agent chemotherapeutic regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

RYSTIGGO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Generalized Myasthenia Gravis (gMG): Anti-AChR antibody positive: The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND The member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND The member has tried or cannot use Vyvgart OR Vyvgart Hytrulo. Generalized Myasthenia Gravis (gMG): Anti-MuSK antibody positive: The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-muscle specific tyrosine kinase (MuSK) antibodies has been confirmed AND The member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND The member has had previous treatment, contraindication, or intolerance to: Pyridostigmine AND At least one immunosuppressive therapy (e.g. azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RYTELO - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Myelodysplastic syndrome (MDS) related anemia: The member has a diagnosis of myelodysplastic syndromes (MDS) AND The member has a low- to intermediate-1 risk disease according to the International Prognostic Scoring System (IPSS) AND The member has transfusion-dependent anemia requiring 4 or more blood cell units over 8 weeks AND The member has not responded to or has lost response to or is ineligible for erythropoiesis-stimulating agents (ESA) (e.g., Retacrit, Procrit).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

RYZNEUTA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation (Note: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy). Requested product will be administered more frequently than once every two weeks.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member has had previous treatment with the following or has an intolerance to the following: Udenyca (pegfilgrastim-cbqv) AND The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (Note: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10-20% and member has at least ONE of the following risk factors applies OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% based on chemotherapy regimen, and at least TWO of the following risk factors apply: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2.0 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Previous neutropenic fever complication or dose-limiting neutropenic event from a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR As secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

SABRIL - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SAIZEN SAIZENPREP - CARTRIDGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

SAIZEN SAIZENPREP - CARTRIDGE (EA)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

sajazir - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Type 1 and 2: The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member is using Firazyr (icatibant) for treatment of acute attacks of HAE. For brand Firazyr requests, the member has had previous treatment or intolerance to generic icatibant. Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response OR describing the side effects observed with generic icatibant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

sajazir - SYRINGE (ML)

Other Criteria	Hereditary Angioedema with normal C1-INH (HAE Type 3): The member must have a diagnosis of hereditary angioedema with normal C1-INH (HAE-nl-C1INH) or type 3. The member must have documented labs showing normal C4 level AND normal C1-INH antigen level AND normal C1-INH functional (%) level. There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered AND The member has episodic angioedema affecting characteristic organs (without urticaria/hives). The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). The member has one of the following: A family history of recurrent angioedema OR Documented labs showing the presence of a mutation associated with HAE-normal-C1INH [i.e. HAE-FXII, HAE-PLG (plasminogen), HAE-ANGPT1 (angiotensinogen-1), and HAE-KNG1 (kininogen-1)]. Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. The member is using icatibant for treatment of acute attacks of HAE. For brand Firazyr requests, the member has had previous treatment or intolerance to generic icatibant. Documentation details must be submitted for one of the following: trial of generic icatibant and the member's response OR describing the side effects observed with generic icatibant.
Part B Prerequisite	0

SAMSCA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use in patients with autosomal dominant polycystic kidney disease (ADPKD) outside of FDA-approved REMS.
Required Medical Information	Tolvaptan (generic Samsca) will be used for the treatment of clinically significant hypervolemic or euvoletic hyponatremia AND tolvaptan (generic Samsca) therapy has been initiated in a hospital. For Brand Request: The member must have had prior therapy, intolerance or contraindication to tolvaptan (generic Samsca).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SANCUSO - PATCH, TRANSDERMAL WEEKLY

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prevention of Chemotherapy induced Nausea and Vomiting: Member will be using Sancuso (granisetron) for the prevention of nausea and vomiting AND Member will be receiving highly emetogenic chemotherapy or moderately emetogenic chemotherapy AND Member will receive chemotherapy for up to five consecutive days. Breakthrough treatment of Chemotherapy induced Nausea and Vomiting: Member will be using Sancuso (granisetron) for the breakthrough treatment of nausea and vomiting related to chemotherapy AND Sancuso (granisetron) will be added to the member's current regimen for breakthrough nausea and vomiting AND Member did not previously use a serotonin-3 (5HT3) receptor antagonist in the same chemotherapy cycle.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SANDOSTATIN - AMPUL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For brand Sandostatin subcutaneous: Member has had prior therapy with or intolerance to generic octreotide AND member must meet clinical criteria below. Acromegaly: The member must have a diagnosis of Acromegaly. must have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have grade 3 or above diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine). Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SANDOSTATIN LAR DEPOT - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For brand Sandostatin subcutaneous: Member has had prior therapy with or intolerance to generic octreotide AND member must meet clinical criteria below. Acromegaly: The member must have a diagnosis of Acromegaly. must have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have grade 3 or above diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine). Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SANTYL - OINTMENT (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Wound Debridement: Member has a chronic dermal ulcer (e.g. pressure ulcer, venous ulcer, diabetic ulcer) or severely burned areas AND Member will be using Santyl (collagenase) for wound debridement.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SAPHNELO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Systemic Lupus Erythematosus (SLE): Initial Treatment - Has a diagnosis of moderate to severe systemic lupus erythematosus AND Prior to initiating therapy, the member is positive for autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm) AND Will be using in combination with standard treatment regimens (e.g. combination of prednisone, hydroxychloroquine, and/or azathioprine) AND Does not have severe active lupus nephritis or severe active nervous system lupus AND Prescribed by or in consultation with a provider who has expertise in treating systemic lupus erythematosus. Continuation of Therapy - Member meets the initial treatment criteria AND Has demonstrated a response to Saphnelo (e.g. achieved low disease activity or improvement in signs and symptoms of the condition).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SAPHRIS - TABLET, SUBLINGUAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia/Bipolar I Disorder, manic or mixed episodes. The member must be utilizing asenapine for treatment of schizophrenia or bipolar I disorder. The member must have prior therapy or intolerance or contraindication to at least two of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

sapropterin - TABLET, SOLUBLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Phenylketonuria (PKU): The member has a diagnosis of PKU AND for brand requests the member has had previous treatment, contraindication, or intolerance to generic sapropterin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SARCLISA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following an anti-CD38 inhibitor (e.g. daratumumab, isatuximab-irfc).
Required Medical Information	Multiple myeloma (third line). The member has a diagnosis of multiple myeloma AND The member will be using Sarclisa (isatuximab-irfc) in combination with Pomalyst (pomalidomide) and dexamethasone (Omission of corticosteroid from regimen is allowed if intolerance/contraindication) AND The member has received at least two prior therapies including Revlimid (lenalidomide) and a proteasome inhibitor (e.g. bortezomib, carfilzomib). Multiple Myeloma (relapsed or refractory): The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will be using Sarclisa (isatuximab-irfc) in combination with carfilzomib and dexamethasone (Omission of corticosteroid from regimen is allowed if intolerance/contraindication) AND The member has received at least one prior therapy. Newly Diagnosed Multiple Myeloma: The member has newly diagnosed multiple myeloma AND The member is ineligible for autologous stem cell transplant AND The member will be using Sarclisa (isatuximab-irfc) in combination with bortezomib, lenalidomide, and dexamethasone.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration
Other Criteria	
Part B Prerequisite	0

SAVAYSA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Nonvalvular Atrial Fibrillation: Savaysa will be used to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. Member has a creatinine clearance of at least 15 mL/min but does not exceed 95 mL/min. The member has had a trial, intolerance, or contraindication to at least two of the following: Eliquis (apixaban), dabigatran, or Xarelto (rivaroxaban). Deep Vein Thrombosis/Pulmonary Embolism: Savaysa will be used for the treatment of deep vein thrombosis and pulmonary embolism. Member will receive a minimum of 5 days of initial therapy with a parenteral anticoagulant while initiating therapy with Savaysa. The member has had a trial, intolerance, or contraindication to at least two of the following: Eliquis (apixaban), dabigatran, or Xarelto (rivaroxaban).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SAVELLA - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Fibromyalgia: Has a diagnosis of fibromyalgia, and has had previous treatment, contraindication, or intolerance to at least TWO of the following: pregabalin, duloxetine, gabapentin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

saxagliptin - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SCSEMBLIX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Scemblix (asciminib).
Required Medical Information	Chronic Myeloid Leukemia (chronic phase): The member has a diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase AND One of the following applies: The member has newly diagnosed disease OR The member has previously treated disease OR The member has T315I mutation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SECUADO - PATCH, TRANSDERMAL 24 HOURS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia: The member has diagnosis of schizophrenia. The member must have prior therapy or intolerance or contraindication to at least two of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, lurasidone.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SEGLENTIS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Management of severe pain. Will be using Seglentis for the management of pain severe enough to require opioid analgesic AND the member has had previous treatment with celecoxib in combination with immediate-release tramadol 50 mg tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SEGLUROMET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 diabetes mellitus: The member has a diagnosis of Type 2 diabetes mellitus AND the member has had previous treatment with, contraindication, or intolerance to: an empagliflozin AND dapagliflozin containing medication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SELARSDI - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SELARSDI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohns disease AND the member has had prior therapy, contraindication, or intolerance with Remicade OR Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SEMGLEE(INSULIN GLARGINE-YFGN) - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of type 1 or type 2 diabetes mellitus AND The member has had previous treatment or intolerance with at least one preferred insulin glargine product: Lantus, Lantus Solostar OR Toujeo AND insulin degludec (i.e. Tresiba).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SEMGLEE(INSULIN GLARG-YFGN)PEN - INSULIN PEN (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of type 1 or type 2 diabetes mellitus AND The member has had previous treatment or intolerance with at least one preferred insulin glargine product: Lantus, Lantus Solostar OR Toujeo AND insulin degludec (i.e. Tresiba).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SEPHIENCE - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Phenylketonuria (PKU): Has a diagnosis of phenylketonuria (PKU) AND Has had previous treatment, contraindication, or intolerance to generic sapropterin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SEREVENT DISKUS - BLISTER, WITH INHALATION DEVICE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema AND the member has had previous treatment, contraindication, or intolerance to Striverdi Respimat. Diagnosis of asthma AND the member has had previous treatment, contraindication, or intolerance to Arnuity Ellipta.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SEROQUEL XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia or bipolar I disorder (manic or mixed episodes):Must have one of the following clinically diagnosed conditions: Schizophrenia or bipolar I disorder, manic or mixed episodes and The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole. Bipolar Depression:The member must have a diagnosis of bipolar depression and the member must have documentation of prior treatment with quetiapine or lurasidone. Major depressive disorder: The member has a clinical diagnosis of major depressive disorder (MDD) as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D) AND The member has had previous treatment, contraindication, or intolerance to at least one antidepressant of adequate dose (i.e. as determined by the treating provider based on individual patient characteristics) and duration (i.e. at least 8 weeks) used as monotherapy for MDD AND The member must have documentation of prior therapy, intolerance, or contraindication to generic quetiapine that has been used as an adjunct (i.e. add-on) to antidepressant therapy AND Seroquel XR must be used as adjunctive treatment to antidepressant therapy and not as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SEROSTIM - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of HIV wasting or cachexia supported with medical records as defined by: Unintended weight loss (greater than 10% plus either unexplained chronic diarrhea (loose/watery for 3 or more times a day) for at least 1 month or reports of fever or night sweats for more than one month without other cause and lack of response to antibiotics or antimalarials or greater than 10% over the past 12 months or greater than 7.5% over 6 months or greater than 5% over 3 months) OR in men Body Cell Mass (BCM) less than 35% of total body weight with BMI less than 27kg/m2, in women BCM less than 23% of total Body Weight with BMI less than 27kg/m2 OR BMI less than 20kg/m2. The member is on concomitant anti-retroviral therapy AND the member has had previous treatment, contraindication, or intolerance with Marinol or Megace.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SIGNIFOR - AMPUL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cushings disease: Diagnosis of Cushings disease AND Pituitary surgery is not an option or has not been curative AND No severe hepatic impairment (Child-Pugh C).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SIGNIFOR LAR - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acromegaly: The member has a diagnosis of acromegaly AND the member has had an inadequate response to pituitary surgery or pituitary surgery is not an option AND the member has had previous treatment, contraindication, or intolerance with the somatostatin analogs: Somatuline Depot (lanreotide) OR Sandostatin LAR AND No severe hepatic impairment (Child-Pugh C). Cushing's disease. The member must have a diagnosis of Cushing's disease AND the member has had an inadequate response to pituitary surgery or pituitary surgery is not an option AND the member does not have severe hepatic impairment (Child-Pugh C).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SIKLOS - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Sickle Cell Anemia: Has a diagnosis of sickle cell disease AND Has had previous treatment or intolerance with both hydroxyurea capsule AND L-glutamine oral packet (generic for Endari) AND Siklos will be discontinued permanently if the member develops hematologic toxicity two times.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

sildenafil (pulm.hypertension) - SUSPENSION, RECONSTITUTED, ORAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH).The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. The member has had prior therapy, contraindication, or intolerance to a phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g., sildenafil or tadalafil).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

sildenafil (pulm.hypertension) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension(PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. For brand Revatio requests only: The member has had prior therapy, contraindication, or intolerance to generic sildenafil (Revatio) tablet OR generic tadalafil (Adcirca) tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SILIQ - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has Crohn's disease.
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SIMLANDI(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

SIMLANDI(CF) - SYRINGE KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

SIMLANDI(CF) AUTOINJECTOR - AUTO-INJECTOR, KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

SIMLANDI(CF) AUTOINJECTOR - AUTO-INJECTOR, KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

SIMPONI - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis: The member must have diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy, contraindication or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. The member must be on concomitant treatment with methotrexate during therapy, unless contraindicated or intolerant to methotrexate. Psoriatic Arthritis: The member must have a diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya. Ankylosing Spondylitis: The member must have a diagnosis of active ankylosing spondylitis. The member has had prior therapy, contraindication or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx or Rinvoq. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member must weigh at least 15 kg. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya.
Age Restriction	Rheumatoid Arthritis, Psoriatic Arthritis, Anklosing Spondylitis: The member must be at least 18 years of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SIMPONI ARIA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Combination therapy with other biologics (e.g. Cosentyx, Enbrel, adalimumab product, Kevzara, Remicade).
Required Medical Information	Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy with or intolerance to a single DMARD (e.g. methotrexate, sulfasalazine, hydroxychloroquine, leflunomide) or contraindication to all DMARDs. The member must be on concomitant treatment with methotrexate during therapy, unless contraindicated or intolerant to methotrexate. Ankylosing Spondylitis: The member must have a diagnosis of active ankylosing spondylitis. The member has had prior therapy, contraindication, or intolerance with at least one NSAID (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis: The member must have a diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with a NSAID (e.g. meloxicam, ibuprofen, naproxen) AND member has had prior therapy with or intolerance to a single DMARD (e.g. sulfasalazine, methotrexate, leflunomide) or contraindication to all DMARDs. Polyarticular Juvenile Idiopathic Arthritis: The member must have a diagnosis of active polyarticular Juvenile Idiopathic Arthritis AND The member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide).
Age Restriction	RA and Ankylosing Spondylitis: 18 years of age or older. PJIA and Psoriatic Arthritis: 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SINEMET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SINGULAIR - TABLET,CHEWABLE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SIRTURO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multidrug-resistant tuberculosis (MDR-TB). The member must have a diagnosis of pulmonary multidrug-resistant tuberculosis (MDR-TB) confirmed by drug susceptibility testing (DST). Bedaquiline will be used as part of a multidrug regimen.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	24 weeks duration
Other Criteria	
Part B Prerequisite	0

sitagliptin - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

sitagliptin-metformin - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SKYCLARYS - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Friedreich's Ataxia: Member has a diagnosis of Friedreich's ataxia AND Diagnosis has been confirmed via genetic testing that shows a GAA triplet-repeat expansion in the frataxin (FXN) gene AND Skyclarys (omaveloxolone) is being prescribed by or in consultation with a provider experienced in the management of Friedreich's ataxia (e.g. neurologist) AND Baseline liver function tests (ALT, AST, bilirubin) have been completed prior to starting therapy, and the provider agrees that these tests will be repeated monthly for the first three months of treatment with Skyclarys (omaveloxolone) AND Baseline B-natriuretic peptide (BNP) and lipid panel have been obtained prior to starting therapy AND Documentation (e.g. chart notes, lab values, genetic testing results) must be submitted to support the requirements above.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SKYRIZI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis. Moderately to severely active Crohns disease: member has a diagnosis of moderately to severely active Crohns disease. Moderately to severely active ulcerative colitis: The member must have a diagnosis of moderately to severely active ulcerative colitis.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SKYTROFA - CARTRIDGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

SKYTROFA - CARTRIDGE (EA)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

sodium oxybate - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Narcolepsy with Cataplexy: The member has a diagnosis of narcolepsy with cataplexy AND for Brand Xyrem requests, previous treatment with sodium oxybate (generic Xyrem). Narcolepsy with excessive daytime sleepiness: The member has a diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria AND the member has condition of excessive daytime sleepiness (EDS) associated with narcolepsy as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND previous treatment, intolerance, or contraindication to at least one CNS stimulant (e.g. methylphenidate, amphetamine salt combination immediate release) or modafinil or armodafinil AND for Brand Xyrem requests, previous treatment with sodium oxybate (generic Xyrem).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	The member will be using no more than one of the following products at any given time: Xyrem (sodium oxybate), Xywav (calcium magnesium, potassium, and sodium oxybates), Lumryz (sodium oxybate), Wakix (pitolisant), or Sunosi (solriamfetol).
Part B Prerequisite	0

SOFDRA - GEL WITH PUMP (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary Axillary Hyperhidrosis: Has a diagnosis of primary axillary hyperhidrosis of at least a 6 month duration AND Has documentation of Hyperhidrosis Disease Severity Scale (HDSS) rating of 3 or 4 AND Has had previous treatment, intolerance, or contraindication to at least one conventional treatment (e.g., aluminum chloride containing antiperspirant, oral oxybutynin).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SOGROYA - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

SOGROYA - PEN INJECTOR (ML)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

SOHONOS - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Fibrodysplasia Ossificans Progressiva (FOP): The member has a diagnosis of fibrodysplasia ossificans progressiva (FOP) AND Sohonos (palovarotene) is consulted with or prescribed by a provider with experience in the management of FOP.
Age Restriction	Member is 8 years of age or older if female and 10 years of age or older if male.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SOLIRIS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH): Documentation in the medical record supporting the diagnosis of PNH defined as granulocyte or monocyte clone size of greater than 5% AND Documentation in the medical record of an LDH level of 1.5 times the upper limit of the normal range AND One of the following: Member is transfusion dependent as defined as one of the following: Hemoglobin less than or equal to 7 g/dL OR Both of the following: Hemoglobin less than or equal to 9 g/dL AND Member is experiencing symptoms of anemia OR Member has a documented history of major adverse vascular events from thromboembolism (e.g., abdominal pain, shortness of breath, chest pain, end organ damage). Atypical Hemolytic Uremic Syndrome (aHUS): Documentation supporting the diagnosis of aHUS by ruling out both of the following: Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS) AND Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Generalized Myasthenia Gravis (gMG): the member has a diagnosis of generalized myasthenia gravis AND the presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND the member is being treated by, or under the supervision of, a specialty (e.g. neurologist) experienced in the management of generalized Myasthenia Gravis AND the member has tried or cannot use Vyvgart OR Vyvgart Hytrulo. Neuromyelitis Optica Spectrum Disorder (NMOSD): the member must have at least one of the core clinical characteristics associated with Neuromyelitis Optica Spectrum Disorder (NMOSD) listed below: optic neuritis, acute myelitis, area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions. The member must be anti-aquaporin-4 (AQP4) antibody positive.
Part B Prerequisite	0

SOLOSEC - GRANULES, DELAYED RELEASE, IN PACKET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Bacterial Vaginosis. Member must have diagnosis of bacterial vaginosis AND member must have had previous treatment, contraindication, or intolerance to metronidazole AND clindamycin. Trichomoniasis: Member must have a diagnosis of trichomoniasis AND Member must have had previous treatment, contraindication, or intolerance to metronidazole AND tinidazole.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SOMATULINE DEPOT - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For brand Somatuline Depot requests: member has had prior therapy with or intolerance to generic lanreotide OR Sandostatin LAR and meets clinical criteria. Diagnosis of acromegaly. The member has a diagnosis of acromegaly. The member has had an inadequate response to or cannot be treated with traditional therapies including surgery and/or radiation therapy. Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs): The member has a diagnosis of unresectable, well- or moderately-differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors. Carcinoid Syndrome: The member has a diagnosis of carcinoid syndrome with symptoms of flushing and/or diarrhea.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SOMAVERT - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acromegaly. The member must have a diagnosis of acromegaly AND The member had inadequate response to surgery or radiation therapy AND The member has had previous treatment, contraindication, or intolerance to one dopamine agonists (i.e. bromocriptine) or one somatostatin analogues (i.e. octreotide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

sorafenib - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on sorafenib. [Applicable to all indications except Gastrointestinal stromal tumor (GIST)]
Required Medical Information	For Brand Nexavar requests: Member must have an intolerance or contraindication to generic sorafenib. Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma (stage IV). Liver Carcinoma: Diagnosis of unresectable hepatocellular (liver) carcinoma. Thyroid Carcinoma. Diagnosis of advanced metastatic medullary carcinoma (thyroid carcinoma) OR The member has a diagnosis of advanced, clinically progressive and/or symptomatic papillary carcinoma, follicular carcinoma or oncocytic carcinoma AND Tumors are not responsive to radio-iodine treatment. Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SOTYKTU - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Sotyktu is not recommended for use in combination with other potent immunosuppressants.
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate-to-severe plaque psoriasis AND The member has had prior therapy, contraindication, or intolerance to two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SOVALDI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Monotherapy with Sovaldi.
Required Medical Information	Chronic Hepatitis C - Adults: Must have a diagnosis of chronic hepatitis C. Member must be non-cirrhotic OR have compensated cirrhosis. Member must have documented Genotype 1, 2, 3, or 4 infection. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance. Chronic Hepatitis C - Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must be non-cirrhotic OR have compensated cirrhosis. Member must have documented Genotype 2 or 3 infection. Sovaldi must be used in combination with ribavirin AND Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa.
Age Restriction	
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Up to 48 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	For all indications, dosing recommendations will be applied consistent with current AASLD-IDSA and compendia guidance.
Part B Prerequisite	0

SPEVIGO - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Generalized Pustular Psoriasis (when NOT experiencing a flare): The member is being prescribed Spevigo and is under the care of a dermatologist or rheumatologist AND The member has a diagnosis of Generalized Pustular Psoriasis and is currently NOT experiencing a flare AND The member has had prior therapy, intolerance, or contraindication to one or more oral systemic treatments (e.g. acitretin, methotrexate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SPEVIGO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Generalized Pustular Psoriasis Flare: The member is being prescribed Spevigo and is under the care of a dermatologist or rheumatologist. The member has a diagnosis of Generalized Pustular Psoriasis and is currently experiencing a flare of moderate-to-severe intensity defined by ALL of the following: Generalized Pustular Psoriasis Global Assessment total score of three or more AND new or worsening pustules AND Generalized Pustular Psoriasis Global Assessment pustulation sub score of two or more AND body surface area involvement of 5% or more with erythema and the presence of pustules. The member has had prior therapy, intolerance, or contraindication to one or more oral systemic treatments (e.g. acitretin, methotrexate) OR conventional oral systemic treatment would be inappropriate due to severity of member's disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SPORANOX - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SPRIX - SPRAY, NON-AEROSOL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Pain. Has a diagnosis of moderate to moderately-severe acute pain. Will be using Sprix for no more than 5 days. Has had a trial with at least TWO of the following oral products: ketorolac, meloxicam, celecoxib capsule, naproxen, ibuprofen, diclofenac, or tramadol 50 mg tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	One month duration
Other Criteria	
Part B Prerequisite	0

SPRYCEL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on dasatinib. For ALL and CML: The member has one of the following mutations: T315I/A, F317L/V/I/C or V299L.
Required Medical Information	Chronic Myelogenous Leukemia (CML): The member has a diagnosis of Ph+ chronic myeloid leukemia (CML) and one of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated and one of the following applies: Intermediate- or high-risk score for disease progression OR Low risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib OR The member has a diagnosis of chronic phase CML that has received previous treatment AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. Acute Lymphoblastic Leukemia (ALL): The member has ALL (Philadelphia Chromosome positive) and dasatinib is being used for induction or consolidation treatment in combination with chemotherapy or corticosteroids OR treatment is for maintenance therapy or the treatment of members with resistance or intolerance to prior therapy AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. Advanced Gastrointestinal Stromal Tumor (GIST): The member has a diagnosis of advanced unresectable GIST. The member has progressive disease or is intolerant to prior therapy with imatinib or sunitinib or Stivarga (regorafenib) AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

SPRYCEL - TABLET

Other Criteria	[Pediatric] Chronic Myelogenous Leukemia (CML). The member has a diagnosis of chronic myeloid leukemia (CML) that is Philadelphia chromosome positive (Ph+) AND the member is in chronic phase AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib. [Pediatric] Acute lymphoblastic leukemia (ALL). The member has a diagnosis of acute lymphoblastic leukemia (ALL) AND the member has Philadelphia chromosome positive (Ph+) disease AND the member has newly-diagnosed disease AND The member will be using dasatinib in combination with chemotherapy AND For brand Sprycel or Phyrago: member must have an intolerance or contraindication to generic dasatinib.
Part B Prerequisite	0

STARJEMZA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

STARJEMZA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohns disease AND the member has had prior therapy, contraindication, or intolerance with Remicade OR Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

STEGLATRO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 diabetes mellitus: The member has a diagnosis of Type 2 diabetes mellitus AND the member has had previous treatment with, contraindication, or intolerance to: an empagliflozin AND dapagliflozin containing medication.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

STEGLUJAN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus. Member must have diagnosis of Type 2 Diabetes Mellitus and member must have previous treatment with, contraindication, or intolerance to the following therapies: One of the following DPP-4 inhibitors: sitagliptin OR linagliptin OR One of the following SGLT2 inhibitors: empagliflozin OR dapagliflozin OR One of the following SGLT2 inhibitor/DPP-4 inhibitor combination drugs: Glyxambi (empagliflozin and linagliptin) OR Trijardy XR (linagliptin, empagliflozin, metformin).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

STELARA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis (SC formulation only): The member must have a diagnosis of moderate to severe chronic plaque psoriasis AND The member has had prior therapy or intolerance to one or more oral systemic treatments (e.g. methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Psoriatic arthritis (SC formulation only): The member must have a diagnosis of active psoriatic arthritis. Moderately to severely active Crohn's disease (IV and SC formulations). The member must have a diagnosis of moderately to severely active Crohn's disease. Moderate to severely active ulcerative colitis (IV and SC formulations): The member must have a diagnosis of moderately to severely active ulcerative colitis.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

STEQUEYMA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

STEQEYMA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohns disease AND the member has had prior therapy, contraindication, or intolerance with Remicade OR Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

STIMUFEND - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND The member must have a diagnosis of non-myeloid malignancy (e.g. Solid Tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.

STIMUFEND - SYRINGE (ML)

Part B Prerequisite	0

STIVARGA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Stivarga (regorafenib). [Applicable to all indications except Gastrointestinal stromal tumor (GIST)]
Required Medical Information	Metastatic Colorectal Cancer. The member has a diagnosis of metastatic colorectal cancer AND The member is using Stivarga (regorafenib) as monotherapy AND The member has experienced disease progression, intolerance, or contraindication with ALL of the following therapies: fluoropyrimidine (regimens include 5-FU/capecitabine), oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, and anti-VEGF therapy (e.g., bevacizumab, ziv-aflibercept) AND If the member is RAS wild-type*, has experienced disease progression, intolerance, or contraindication with anti-EGFR therapy (e.g., cetuximab, panitumumab). *This criteria only applies to left sided tumors. Gastrointestinal Stromal Tumor. The member has a diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor AND The member has experienced disease progression, intolerance, or contraindication with imatinib mesylate and sunitinib malate. Hepatobiliary Cancers: The member has a diagnosis of hepatocellular carcinoma AND Stivarga (regorafenib) is being given as monotherapy AND The member has experienced progression after first line therapy (e.g., sorafenib). Soft Tissue sarcoma. Diagnosis of advanced or metastatic soft tissue sarcoma (e.g., angiosarcoma, non-adipocytic sarcoma, pleomorphic rhabdomyosarcoma) AND Stivarga (regorafenib) is being given as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Month Duration
Other Criteria	
Part B Prerequisite	0

STRATTERA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

STRENSIQ - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hypophosphatasia (HPP): The member must have a diagnosis of perinatal-onset, infantile-onset, or juvenile-onset hypophosphatasia based on the following criteria: one of the following: clinical signs and symptoms supporting onset of hypophosphatasia prior to 18 years of age OR radiographic evidence supporting hypophosphatasia diagnoses prior to 18 years of age AND one of the following: documented gene mutation of tissue-nonspecific alkaline phosphatase (TNSALP) OR Low total serum alkaline phosphatase (ALP) activity determined by the gender- and age-specific reference range, AND Elevated urine concentration of phosphoethanolamine (PEA) determined by age-specific reference range, OR Elevated serum pyridoxal 5'-phosphate (PLP) level (normal range 5 - 50 mcg/L), OR Documented gene mutation of tissue-nonspecific alkaline phosphatase (TNSALP).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

STROMEKTOL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SUBOXONE - FILM, MEDICATED (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Treatment of Opioid Dependence: Is using the requested product for the treatment of opioid dependence AND has had previous treatment or intolerance with BOTH of the following: generic buprenorphine/naloxone sublingual tablet AND Zubsolv sublingual tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SUCRAID - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Congenital sucrase-isomaltase deficiency (CSID): Member has a diagnosis of congenital sucrase-isomaltase deficiency (CSID) confirmed by one of the following: Small bowel biopsy with disaccharidase assay (including lactase, sucrase, isomaltase, and maltase) OR Sucrose breath hydrogen test OR 13C-sucrose breath test AND Member does not have secondary (acquired) disaccharidase deficiency AND Sucraid (sacrosidase) will be used with a sucrose- and starch-restricted diet AND Sucraid (sacrosidase) is prescribed by or in consultation with a specialist with experience treating CSID (e.g., gastroenterologist, rare disease specialist).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SULAR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

sunitinib malate - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Sutent. [Applicable to all indications except Gastrointestinal stromal tumor (GIST)]. Member not to exceed a total treatment of 54 weeks [applicable to adjuvant therapy for renal cell carcinoma].
Required Medical Information	For brand Sutent requests: Member must have an intolerance or contraindication to generic sunitinib AND member must meet clinical criteria below. Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST) AND the member has disease progression on or intolerance to imatinib mesylate. Advanced renal cell carcinoma(RCC).Diagnosis of advanced renal cell carcinoma (stage IV). Renal Cell Carcinoma (RCC) Adjuvant Therapy. The member has high risk (i.e. tumor stage T3 or higher, regional lymph node metastases, or both) of recurrent RCC following nephrectomy AND Sutent (sunitinib) will be used as a single agent as adjuvant treatment. Pancreatic neuroendocrine tumors (PNET). Diagnosis of Progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) AND The member has unresectable locally advanced or metastatic disease. Advanced Thyroid Carcinoma. Diagnosis of advanced/metastatic follicular, oncocyctic, papillary carcinoma OR The member has a diagnosis of advanced medullary carcinoma and has disease progression or has an intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Advanced/Metastatic Angiosarcoma. Diagnosis of diagnosis of advanced/metastatic angiosarcoma AND Sutent (sunitinib) is being utilized as a single agent/monotherapy (without concomitant chemotherapy or biologics). Thymomas/thymic carcinoma: The member has a diagnosis of thymic carcinoma/thymomas and the member will be using as monotherapy in the second line.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SUNOSI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Narcolepsy: The member has a diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria AND the member has condition of excessive daytime sleepiness associated with narcolepsy as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND the member has previous treatment, contraindication, or intolerance with at least one CNS stimulant (e.g., methylphenidate, amphetamine salt combination immediate release) AND modafinil OR armodafinil. Obstructive Sleep Apnea: The member has diagnosis of obstructive sleep apnea (OSA) according to ICSD-3 criteria AND the member has condition of excessive daytime sleepiness associated with OSA as confirmed by documented sleep testing (e.g. polysomnography, home testing) AND the member has sleep-related symptoms of OSA after compliant continuous positive airway pressure (CPAP) use as monotherapy for at least one month prior to initiating Sunosi AND the member will continue with modalities to treat the underlying airway obstruction during treatment with Sunosi AND the member has previous treatment, contraindication, or intolerance with modafinil OR armodafinil after CPAP therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	The member will be using no more than one of the following products at any given time: Lumryz (sodium oxybate), Xyrem (sodium oxybate), Xywav (calcium magnesium, potassium, and sodium oxybates), Sunosi (solriamfetol), or Wakix (pitolisant).
Part B Prerequisite	0

SUTENT - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Sutent. [Applicable to all indications except Gastrointestinal stromal tumor (GIST)]. Member not to exceed a total treatment of 54 weeks [applicable to adjuvant therapy for renal cell carcinoma].
Required Medical Information	For brand Sutent requests: Member must have an intolerance or contraindication to generic sunitinib AND member must meet clinical criteria below. Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST) AND the member has disease progression on or intolerance to imatinib mesylate. Advanced renal cell carcinoma(RCC).Diagnosis of advanced renal cell carcinoma (stage IV). Renal Cell Carcinoma (RCC) Adjuvant Therapy. The member has high risk (i.e. tumor stage T3 or higher, regional lymph node metastases, or both) of recurrent RCC following nephrectomy AND Sutent (sunitinib) will be used as a single agent as adjuvant treatment. Pancreatic neuroendocrine tumors (PNET). Diagnosis of Progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) AND The member has unresectable locally advanced or metastatic disease. Advanced Thyroid Carcinoma. Diagnosis of advanced/metastatic follicular, oncocytic, papillary carcinoma OR The member has a diagnosis of advanced medullary carcinoma and has disease progression or has an intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Advanced/Metastatic Angiosarcoma. Diagnosis of diagnosis of advanced/metastatic angiosarcoma AND Sutent (sunitinib) is being utilized as a single agent/monotherapy (without concomitant chemotherapy or biologics). Thymomas/thymic carcinoma: The member has a diagnosis of thymic carcinoma/thymomas and the member will be using as monotherapy in the second line.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SYLVANT - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	NA
Required Medical Information	Multicentric Castleman's Disease: The member has a diagnosis of multicentric Castleman's disease. The member is human immunodeficiency (HIV) and human herpes virus (HHV-8) negative. The member has an absolute neutrophil count greater than or equal to $1.0 \times 10^9/L$, a platelet count of greater than or equal to 75×10^9 , and hemoglobin level less than 17 g/dL. Reauthorization Criteria: The approval duration may be continued for 6 additional months if benefit is shown via no evidence of disease progression/treatment failure and the following laboratory parameters are met: The member has an absolute neutrophil count greater than or equal $1.0 \times 10^9/L$, a platelet count of greater than or equal 50×10^9 , and hemoglobin level less than 17 g/dL.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	NA
Part B Prerequisite	0

SYMDEKO - TABLET, SEQUENTIAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis: The member must meet ALL of the following criteria: Diagnosis of Cystic Fibrosis AND Prior lab testing with documentation of a mutation in the CFTR gene that is responsive to therapy based on clinical literature and/or in vitro assay data AND Previous treatment, contraindication, or intolerance to Trikafta.
Age Restriction	
Prescriber Restriction	The member is being treated by or in consultation with a specialist (e.g. pulmonologist).
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

SYMPAZAN - FILM, MEDICATED (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Lennox-Gastaut Syndrome: The member has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) AND Sympazan (clobazam film) will be used in combination with at least one other drug for controlling seizures AND the member has had prior therapy with AND has a documented contraindication (e.g., dysphagia) to BOTH generic clobazam tablet AND oral suspension formulation.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SYMPROIC - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has a diagnosis of opioid-induced constipation AND Member has taken an opioid agonist for at least 4 weeks for non-cancer pain, including pain related to prior cancer or its treatment that does not require frequent (e.g., weekly) opioid dose increases AND Member must have had previous treatment, intolerance, or contraindication to lubiprostone AND Movantik (naloxegol).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

SYNAGIS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prematurity: Infants born less than or equal to 35 weeks gestation age AND less than 6 months old (chronologic age) at the start of RSV season. Bronchopulmonary Dysplasia: Infants who are 24 months of age or younger at the start of RSV season AND required medical treatment for bronchopulmonary dysplasia within previous 6 months. Congenital Heart Disease (CHD): Infants and children who are 24 months of age or younger at the start of RSV season AND diagnosed with hemodynamically significant heart disease. (e.g. receiving medication to control congestive heart failure, moderate to severe pulmonary hypertension, cyanotic heart disease).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	RSV Season Based on Geographic Location: Variations in the onset and offset of the RSV season in the state of Florida affect the timing of Synagis (palivizumab) administration. For this reason, infants and young children in Florida who qualify for prophylaxis for the season should receive Synagis (palivizumab) only as required for periods in the state of Florida.
Part B Prerequisite	0

SYPRINE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TABRECTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Tabrecta (capmatinib).
Required Medical Information	Non-Small Lung Cell Cancer (NSCLC): The member has a diagnosis of metastatic NSCLC AND the disease is documented MET exon 14 skipping positive.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TACLONEX - SUSPENSION, TOPICAL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Psoriasis: The member must have a diagnosis of plaque psoriasis AND has had previous treatment, contraindication or intolerance with a high potency corticosteroid (e.g. triamcinolone 0.5%, betamethasone dipropionate/dipropionate augmented, or clobetasol cream/ointment).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tadalafil - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Benign Prostatic Hyperplasia (BPH). The member has a diagnosis of benign prostatic hyperplasia (BPH). The member has failed previous treatment or has a contraindication/intolerance to an alpha blocker (i.e. terazosin, doxazosin, tamsulosin, alfuzosin) AND a 5-alpha reductase inhibitor (i.e. finasteride, dutasteride).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tadalafil (pulm. hypertension) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

TADLIQ - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization. The member must have had prior therapy, intolerance or contraindication to sildenafil (generic Revatio) or tadalafil (generic Adcirca) for the treatment of PAH (WHO Group I).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TAFINLAR - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Melanoma - Unresectable or metastatic: Concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Zelboraf (vemurafenib), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Experienced disease progression on Tafinlar (dabrafenib). Experienced disease progression on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)]. Anaplastic Thyroid Cancer, Metastatic Solid Tumors: Concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Experienced disease progression on Tafinlar (dabrafenib). Experienced disease progression on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)]. NSCLC: Concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Experienced disease progression on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)]. Adjuvant melanoma: Taking Tafinlar (dabrafenib) total treatment for more than 1 year. Concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Zelboraf (vemurafenib), Cotellic (cobimetinib), Braftovi (encorafenib), or Mektovi (binimetinib). Experienced disease progression on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)]. LGG: Experienced disease progression on Tafinlar (dabrafenib). Experienced disease progression on prior anti-BRAF/MEK combination therapy [e.g. Cotellic (cobimetinib) with Zelboraf (vemurafenib) or Braftovi (encorafenib) with Mektovi (binimetinib)].

TAFINLAR - CAPSULE

Required Medical Information	Melanoma - Unresectable or Metastatic: The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND The member will be using Tafinlar (dabrafenib) as monotherapy OR in combination with Mekinist (trametinib). Non-small cell lung cancer: The member has a diagnosis of recurrent or metastatic non-small cell lung cancer (NSCLC) AND The member has a documented BRAF V600E mutation AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib). Melanoma - Adjuvant. The member has a diagnosis of stage III melanoma AND The member has undergone lymph node resection of involved lymph nodes AND The member has a documented BRAF V600 activating mutation AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib) for adjuvant treatment. Anaplastic Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic anaplastic thyroid cancer AND The member has a documented V600E mutation AND The member has no satisfactory locoregional treatment options AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib). Metastatic Solid Tumors: the member has a diagnosis of unresectable or metastatic solid tumors with documented BRAF V600E mutation AND the member has disease that has progressed on prior therapy and has no satisfactory alternative treatments AND Tafinlar is given in combination with Mekinist. Low-grad Glioma: The member has a diagnosis of low-grade glioma (LGG) AND The member has a documented BRAF V600E mutation AND Tafinlar (dabrafenib) will be used in combination with Mekinist (trametinib).
Age Restriction	Low-grade Glioma only: The member is a pediatric age 1 year of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TAGRISSO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members who have disease progression on Tagrisso (osimertinib) (applicable to adjuvant therapy in NSCLC and NSCLC locally advanced, unresectable stage III). Total treatment exceeds three years (applicable to adjuvant therapy in NSCLC).
Required Medical Information	Non small cell lung cancer NSCLC: The member has a diagnosis of advanced or metastatic non small cell lung cancer (NSCLC) and ONE of the following criteria applies: The member has documented sensitizing EGFR mutations (exon 19 deletions or exon 21 L858R) AND Tagrisso (osimertinib) is being used as single agent for first line therapy OR Tagrisso (osimertinib) is being used in combination with pemetrexed and platinum-based chemotherapy (e.g., cisplatin, carboplatin) as first-line therapy OR The member has a diagnosis of advanced or metastatic non small cell lung cancer (NSCLC) and The member has a documented epidermal growth factor receptor (EGFR) T790M mutation AND Tagrisso (osimertinib) is used as monotherapy after progression of EGFR inhibitors (e.g., erlotinib, gefitinib). Non-small cell lung cancer (NSCLC) [Adjuvant therapy]: The member has a diagnosis of NSCLC (i.e., Stage IB- IIIA) AND The member has documented sensitizing EGFR mutations (exon 19 deletions or exon 21 L858R) AND The tumor has been resected AND Member will be taking (osimertinib) as a single agent for adjuvant therapy. Non-small cell lung cancer (NSCLC) - Locally Advanced, Unresectable [Stage III]: The member has a diagnosis of locally advanced, unresectable (stage III) NSCLC AND The disease has not progressed during or following concurrent or sequential platinum-based chemoradiation therapy AND The member has a documented sensitizing EGFR mutation (exon 19 deletion or exon 21 L858R) AND Tagrisso (osimertinib) will be given as a single agent as consolidation therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TAKHZYRO - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) Prophylaxis. The member must have a diagnosis of hereditary angioedema (HAE) type 1 or type 2. The member must have documentation of: Evidence of C4 level consistent with diagnosis of HAE Type 1 or 2 AND C1 inhibitor (C1INH) antigenic level consistent with diagnosis of HAE Type 1 or 2 OR C1INH functional level consistent with diagnosis of HAE Type 1 or 2 OR Known HAE-causing C1INH mutation AND The member has a history of recurrent angioedema in the absence of concomitant urticaria AND There are no concomitant or recent use of medications known to cause angioedema (e.g. ACEIs, ARBs) AND Other potential causes of angioedema have been ruled out or considered. The member is being treated by a specialist in hereditary angioedema (i.e. allergist and/or immunologist). Must provide lab report or medical record documentation which include lab values as required by policy. Lab values must include C1q level that is consistent with the diagnosis of HAE. Note: according to the US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema, "C1q level is useful to help distinguish between HAE-C1INH and acquired C1INH deficiency. C1q levels are decreased in 80% of acquired C1INH deficiency and rarely low in HAE-C1INH". The member must be using Takhzyro for prophylaxis to prevent attacks of HAE. The member has had previous treatment, contraindication or intolerance with appropriately dosed Haegarda (C1 esterase inhibitor) for HAE prophylaxis. Documentation details must be submitted for one of the following: trial of Haegarda and the member's response, member's specific contraindication to Haegarda, OR describing the side effects observed with Haegarda.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TALTZ AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya. Ankylosing Spondylitis: the member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx or Rinvoq. Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, and Rinvoq.
Age Restriction	Must be 6 years of age or older for Plaque Psoriasis and 18 years of age or older for Psoriatic Arthritis, Ankylosing Spondylitis, and nr-axSpA.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TALTZ AUTOINJECTOR (2 PACK) - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya. Ankylosing Spondylitis: the member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx or Rinvoq. Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, and Rinvoq.
Age Restriction	Must be 6 years of age or older for Plaque Psoriasis and 18 years of age or older for Psoriatic Arthritis, Ankylosing Spondylitis, and nr-axSpA.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TALTZ AUTOINJECTOR (3 PACK) - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya. Ankylosing Spondylitis: the member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx or Rinvoq. Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, and Rinvoq.
Age Restriction	Must be 6 years of age or older for Plaque Psoriasis and 18 years of age or older for Psoriatic Arthritis, Ankylosing Spondylitis, and nr-axSpA.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TALTZ SYRINGE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya. Ankylosing Spondylitis: the member has a diagnosis of active ankylosing spondylitis AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx or Rinvoq. Non-radiographic Axial Spondyloarthritis: The member has a diagnosis of non-radiographic axial spondyloarthritis with signs of inflammation AND the member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Cosentyx, and Rinvoq.
Age Restriction	Must be 6 years of age or older for Plaque Psoriasis and 18 years of age or older for Psoriatic Arthritis, Ankylosing Spondylitis, and nr-axSpA.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TALVEY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Talvey (talquetamab).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member has relapsed/refractory disease AND The member has received at least four prior lines of therapy, including an anti-CD38 monoclonal antibody (e.g. daratumumab), a proteasome inhibitor (e.g. bortezomib), and an immunomodulatory agent (e.g. lenalidomide) AND The member is using Talvey (talquetamab) as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TALZENNA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members have experienced disease progression while on or following PARP inhibitor therapy (eg, olaparib).
Required Medical Information	Breast Cancer. Member has a diagnosis of locally advanced or metastatic, HER-2 negative breast cancer AND Member has documented deleterious germline or suspected germline BRCA mutated disease AND if member has hormone receptor positive disease then is endocrine refractory AND Talzenna (talazoparib) will be used as monotherapy. Metastatic Castration-Resistant Prostate Cancer (mCRPC). Member has a diagnosis of Metastatic Castration-Resistant Prostate Cancer (mCRPC) AND Member has a documented (HRR) gene-mutated disease AND Member will use Talzenna (talazoparib) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]) AND Talzenna (talazoparib) is given in combination with Xtandi (enzalutamide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TAMIFLU - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tanlor - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Musculoskeletal Pain: member is using this product as adjunct to rest, physical therapy, and other measures for relief of musculoskeletal pain associated with acute, painful musculoskeletal conditions AND has had a trial with, intolerance, or contraindication to methocarbamol 500 mg tablets AND 750 mg tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TARCEVA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For brand Tarceva requests: Member must have an intolerance or contraindication to generic erlotinib AND member must meet clinical criteria below. Pancreatic Cancer: The member has a diagnosis of unresectable, locally advanced or metastatic pancreatic cancer. AND erlotinib is being used in combination with gemcitabine. Non-small cell lung cancer. The member has a diagnosis of metastatic NSCLC AND all of the following apply: The member has known documented activated EGFR mutation (such as E19del in exon 19 or L858R in exon 21). Renal Cell Carcinoma: Diagnosis of relapsed or unresectable stage IV renal cell carcinoma with non-clear histology.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

TARGRETIN - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that are pregnant.
Required Medical Information	Cutaneous T-cell Lymphoma (CTCL). (bexarotene capsules). The member will be using bexarotene as primary treatment OR Member has experienced disease progression, contraindication, or intolerance to at least one prior systemic therapy for cutaneous manifestations of cutaneous T-cell lymphoma. Cutaneous T-cell Lymphoma. (bexarotene 1% topical gel/jelly). The member will be using bexarotene as primary treatment OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TARPEYO - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary immunoglobulin A nephropathy (IgAN): Member has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy AND Tarpeyo is being used to reduce the loss of kidney function in those who are at risk for disease progression.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TASCENSO ODT - TABLET,DISINTEGRATING

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TASIGNA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on any nilotinib product. For ALL and CML: The member has one of the following mutations: T315I, Y253H, E255K/V, or F359V/C/I.
Required Medical Information	Chronic Myelogenous Leukemia (CML). The member has a diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (CML) AND One of the following applies: The member has accelerated or blast phase CML OR The member has a diagnosis of chronic phase CML that has not been previously treated, and one of the following applies: Intermediate- or high-risk score for disease progression OR Low-risk score for disease progression and has contraindication to, intolerance to, or unable to achieve treatment goals with imatinib OR The members has a diagnosis of chronic phase CML that has received previous treatment AND For brand Tasigna: member must have an intolerance or contraindication to generic nilotinib. Advanced Gastrointestinal Stromal Tumor (GIST). Diagnosis of advanced unresectable GIST. The member has progressive disease or is intolerant to prior therapy with imatinib, sunitinib, or Stivarga (regorafenib) AND For brand Tasigna: member must have an intolerance or contraindication to generic nilotinib. Acute Lymphoblastic Leukemia (ALL). The member has diagnosis of Philadelphia positive acute lymphoblastic leukemia AND For brand Tasigna: member must have an intolerance or contraindication to generic nilotinib. Pediatric CML: Diagnosis of chronic phase Ph+ chronic myeloid leukemia (CML) OR Diagnosis of accelerated phase Ph+ chronic myeloid leukemia (CML) AND resistance, intolerance, or contraindication to prior TKI therapy AND For brand Tasigna: member must have an intolerance or contraindication to generic nilotinib.
Age Restriction	Pediatric CML- member is greater than or equal to 1 year of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

tasimelteon - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-24-Hour Sleep-Wake Disorder. The member has a documented diagnosis of Non-24-Hour Sleep-Wake Disorder AND For BRAND Hetlioz or Hetlioz LQ requests the member has had previous treatment or intolerance to generic tasimelteon capsules. Smith-Magenis Syndrome (SMS): The member has a documented diagnosis of SMS AND documented evidence of nighttime sleep disturbances associated with SMS AND For BRAND Hetlioz or Hetlioz LQ requests for ages 16 years and older, the member has had previous treatment or intolerance to generic tasimelteon capsules.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TASMAR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease: Member has a diagnosis of Parkinson's Disease AND The member is currently taking levodopa/carbidopa and is experiencing symptom fluctuations AND The member has tried or cannot use entacapone and at least one other drug as adjunct therapy for Parkinson's Disease (e.g. pramipexole, ropinirole, selegiline, rasagiline) AND The member will take Tasmar (tolcapone) in combination with levodopa/carbidopa AND Baseline liver function tests have been performed to rule out underlying liver disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tavaborole - SOLUTION WITH APPLICATOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Onychomycosis: The member has a diagnosis of onychomycosis of the toenails caused by Trichophyton rubrum or Trichophyton mentagrophytes AND Member has had previous treatment, contraindication, or intolerance to oral terbinafine and at least one of the following: itraconazole, ciclopirox nail solution, griseofulvin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TAVALISSE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Immune Thrombocytopenia (ITP). Initial approval: the member has a diagnosis of relapsed/refractory chronic ITP AND the member has a platelet count of less than 50,000 per microliter AND the member has had an insufficient response or is intolerant to Promacta OR Nplate. Reauthorization: The member is responding to therapy as evidenced by increased platelet counts, maintenance of platelet counts, and/or a decreased frequency of bleeding episodes.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: 6 Months Duration. Reauth: Plan year duration.
Other Criteria	
Part B Prerequisite	0

TAVNEOS - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Initial Authorization: The member has a clinical diagnosis of granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA) AND The member has a positive test for either antiproteinase 3 (PR3) or antimyeloperoxidase (MPO) AND The member has severe disease, as indicated by the presence of life or organ threatening manifestations (e.g. alveolar hemorrhage, glomerulonephritis, central nervous system vasculitis, mononeuritis multiplex, cardiac involvement, mesenteric ischemia or limb/digit ischemia) AND Tavneos (avacopan) is prescribed by or in consultation with a rheumatologist or other provider who has experience in treating ANCA-associated vasculitis AND The member will be using Tavneos (avacopan) with standard therapy for severe ANCA associated vasculitis (e.g., cyclophosphamide, rituximab, and glucocorticoids). Reauthorization: Documentation of positive clinical response to Tavneos therapy, as evidenced by: Stabilization of disease or absence of disease progression. The member will be using Tavneos (avacopan) with standard therapy for severe AAV (e.g., rituximab, azathioprine, methotrexate, mycophenolate mofetil).
Age Restriction	The member is 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

tazarotene - FOAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Cosmetic indications including solar lentigines, wrinkles, or roughness of the skin in the absence of an approvable indication described in the coverage determination section.
Required Medical Information	Acne Vulgaris. The member must have a diagnosis of acne vulgaris AND The member must have had previous treatment with, intolerance or contraindication to tretinoin (non-micro) or adapalene 0.1% gel.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tazarotene - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Cosmetic indications including solar lentigines, wrinkles, or roughness of the skin in the absence of an approvable indication described in the coverage determination section.
Required Medical Information	The treatment of acne vulgaris: The member must have a documented diagnosis of acne vulgaris AND The member must have had previous treatment, or intolerance to generic topical tretinoin (non-micro)*. The treatment of stable plaque psoriasis: The member must have a documented diagnosis of stable plaque psoriasis AND The member must have had previous treatment , intolerance, or contraindication with topical betamethasone dipropionate or triamcinolone 0.5%. *Generic topical tretinoin (non-micro) has additional prior authorization requirements.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TAZORAC - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Cosmetic indications including solar lentigines, wrinkles, or roughness of the skin in the absence of an approvable indication described in the coverage determination section.
Required Medical Information	The treatment of acne vulgaris: The member must have a documented diagnosis of acne vulgaris AND The member must have had previous treatment, or intolerance to generic topical tretinoin (non-micro)*. The treatment of stable plaque psoriasis: The member must have a documented diagnosis of stable plaque psoriasis AND The member must have had previous treatment , intolerance, or contraindication with topical betamethasone dipropionate or triamcinolone 0.5%. *Generic topical tretinoin (non-micro) has additional prior authorization requirements.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TAZVERIK - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member experiences disease progression on Tazverik
Required Medical Information	Epithelioid Sarcoma: The member has a diagnosis of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection AND Tazverik will be given as monotherapy. Follicular lymphoma: The member has a diagnosis of relapsed/refractory follicular lymphoma AND one of the following applies: The member has a documented EZH2 mutation by an FDA approved test and the member has received at least two prior therapies and the member will be using Tazverik (tazemetostat) as monotherapy OR The member has no satisfactory alternative treatment options and The member will be using Tazverik (tazemetostat) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TECENTRIQ - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression while on or following anti-PD-1/PD-L1 therapy (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab], Bavencio [avelumab]). Adjuvant setting for Non-Small Cell Lung Cancer: member is taking Tecentriq (atezolizumab) total treatment for more than one year.
Required Medical Information	Non-Small Cell Lung Cancer (advanced or metastatic frontline): The member has a diagnosis of advanced or metastatic NSCLC AND member has disease with no EGFR or ALK genomic tumor aberrations and one of the following scenarios is applied: The member has non-squamous cell histology AND Tecentriq will be given as a component of one of the two combo regimens: in combination with carboplatin and paclitaxel and Bevacizumab Product as first line therapy followed by maintenance therapy with combination an atezolizumab product and Bevacizumab Product OR in combo with Abraxane (nabpaclitaxel) and carboplatin as first line therapy. OR Disease has high PD-L1 expression [PD-L1 stained greater than or equal to 50% of tumor cells OR PD-L1 stained tumor-infiltrating immune cells covering greater than or equal to 10% of the tumor area] AND PD-L1 tumor expression is determined by an FDA-approved test AND will be given as first-line therapy AND The member will be using as monotherapy. Non-Small Cell Lung Cancer (metastatic - subsequent): The member has a diagnosis of metastatic non-small cell lung carcinoma AND The member has experienced disease progression on or after chemotherapy and EGFR inhibitor or ALK inhibitor (post confirmed EGFR or ALK genomic tumor aberration positivity) AND atezolizumab product will be used as monotherapy. Alveolar Soft Part Sarcoma (ASPS): The member has a diagnosis of unresectable or metastatic alveolar soft part sarcoma AND The member will be using an atezolizumab product as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

TECENTRIQ - VIAL (ML)

Other Criteria	Small Cell Lung Cancer: The member has a diagnosis of extensive-stage small cell lung cancer AND atezolizumab product will be given in combination with etoposide and carboplatin as first line therapy followed by maintenance therapy with atezolizumab product, either as monotherapy or in combination with Zepzelca (lurbinectedin). Hepatocellular Carcinoma: The member has a diagnosis of unresectable or metastatic hepatocellular carcinoma AND atezolizumab product will be used as first line therapy in combination with bevacizumab product. Melanoma: The member has a diagnosis of unresectable or metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND the member will use an atezolizumab product in combination with Cotellic (cobimetinib) and Zelboraf (vemurafenib). Non-Small Cell Lung Cancer (Adjuvant): The member must have a diagnosis of Stage II to IIIA non-small cell lung cancer AND The disease has expression of PD-L1 on greater than or equal to 1% of tumor cells as determined by an FDA-approved test AND The member is post complete surgical resection and adjuvant platinum-based chemotherapy AND The member will be using an atezolizumab product as monotherapy in the adjuvant setting.
Part B Prerequisite	0

TECENTRIQ HYBREZA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Disease progression while on or following anti-PD-1/PD-L1 therapy (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab], Bavencio [avelumab]). Adjuvant setting for Non-Small Cell Lung Cancer: member is taking Tecentriq (atezolizumab) total treatment for more than one year.
Required Medical Information	Non-Small Cell Lung Cancer (advanced or metastatic frontline): The member has a diagnosis of advanced or metastatic NSCLC AND member has disease with no EGFR or ALK genomic tumor aberrations and one of the following scenarios is applied: The member has non-squamous cell histology AND Tecentriq will be given as a component of one of the two combo regimens: in combination with carboplatin and paclitaxel and Bevacizumab Product as first line therapy followed by maintenance therapy with combination an atezolizumab product and Bevacizumab Product OR in combo with Abraxane (nabpaclitaxel) and carboplatin as first line therapy. OR Disease has high PD-L1 expression [PD-L1 stained greater than or equal to 50% of tumor cells OR PD-L1 stained tumor-infiltrating immune cells covering greater than or equal to 10% of the tumor area] AND PD-L1 tumor expression is determined by an FDA-approved test AND will be given as first-line therapy AND The member will be using as monotherapy. Non-Small Cell Lung Cancer (metastatic - subsequent): The member has a diagnosis of metastatic non-small cell lung carcinoma AND The member has experienced disease progression on or after chemotherapy and EGFR inhibitor or ALK inhibitor (post confirmed EGFR or ALK genomic tumor aberration positivity) AND atezolizumab product will be used as monotherapy. Alveolar Soft Part Sarcoma (ASPS): The member has a diagnosis of unresectable or metastatic alveolar soft part sarcoma AND The member will be using an atezolizumab product as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration

TECENTRIQ HYBREZA - VIAL (ML)

Other Criteria	Small Cell Lung Cancer: The member has a diagnosis of extensive-stage small cell lung cancer AND atezolizumab product will be given in combination with etoposide and carboplatin as first line therapy followed by maintenance therapy with atezolizumab product, either as monotherapy or in combination with Zepzelca (lurbinectedin). Hepatocellular Carcinoma: The member has a diagnosis of unresectable or metastatic hepatocellular carcinoma AND atezolizumab product will be used as first line therapy in combination with bevacizumab product. Melanoma: The member has a diagnosis of unresectable or metastatic melanoma AND The member has a documented BRAF V600 activating mutation AND the member will use an atezolizumab product in combination with Cotellic (cobimetinib) and Zelboraf (vemurafenib). Non-Small Cell Lung Cancer (Adjuvant): The member must have a diagnosis of Stage II to IIIA non-small cell lung cancer AND The disease has expression of PD-L1 on greater than or equal to 1% of tumor cells as determined by an FDA-approved test AND The member is post complete surgical resection and adjuvant platinum-based chemotherapy AND The member will be using an atezolizumab product as monotherapy in the adjuvant setting.
Part B Prerequisite	0

TECFIDERA - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TECVAYLI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on bispecific B-cell maturation antigen (BCMA)-directed CD3 T-cell engager-containing regimen.
Required Medical Information	Multiple Myeloma. The member has a diagnosis of multiple myeloma AND the member has relapsed/refractory disease AND the member has received at least four prior lines of therapy, including an anti-CD38 monoclonal antibody (e.g. daratumumab), a proteasome inhibitor (e.g. bortezomib), and an immunomodulatory agent (e.g. lenalidomide) AND the member is using Tecvayli (teclistamab-cqyv) as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TEGLUTIK - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): The member has a diagnosis of amyotrophic lateral sclerosis AND the member has previous treatment AND a documented contraindication to riluzole tablets (e.g. impaired ability to swallow tablets).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TEKTURNA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TEMODAR - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Temozolomide is contraindicated in member with a history of hypersensitivity to dacarbazine.
Required Medical Information	Glioblastoma Multiforme/ Anaplastic Astrocytoma: The member is an adult with glioblastoma multiforme (GBM) or anaplastic astrocytoma and Temodar (temozolomide) is being used as the following: Newly diagnosed GBM or anaplastic astrocytoma as a single agent or in combination with radiotherapy OR Maintenance therapy for GBM or anaplastic astrocytoma or treatment of recurrent disease as a single agent or in combination with bevacizumab product for GBM or anaplastic astrocytoma. Low Grade Gliomas: The member is an adult with low grade infiltrative supratentorial astrocytoma or oligodendroglioma AND The member has disease progression on a regimen containing carmustine, lomustine, or procarbazine AND The member must use Temodar (temozolomide) as a single agent for recurrent or progressive disease OR The member must use Temodar (temozolomide) as a single agent as adjuvant therapy. Ewing's Sarcoma: The member has Ewing's sarcoma and Temodar (temozolomide) is being used in combination with irinotecan for one of the following: Relapse therapy. Progressive disease following primary treatment. Melanoma: The member has diagnosis of unresectable or recurrent melanoma and Temodar (temozolomide) is being used as a single agent for subsequent therapy. Neuroendocrine Tumors of the Pancreas: The member has diagnosis of unresectable locoregional and/or distant metastatic neuroendocrine tumors of the pancreas (islet cell tumors) and Temodar is being as single agent or in combo with Xeloda for the management of symptomatic disease, clinically significant tumor burden or clinically significant progression.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

TEMODAR - VIAL (EA)

Other Criteria	Neuroendocrine Tumors of the Lung or Thymus: The member has locoregional or metastatic neuroendocrine carcinoma and Temodar (temozolomide) is being used as a single agent. Mycosis fungoides (MF)/Sezary syndrome(SS): The member has a diagnosis of MF/SS. Primary Central Nervous System (CNS) Lymphoma: The member has a diagnosis of primary CNS lymphoma and will be using Temodar (temozolomide) in combination with high-dose methotrexate and rituximab product OR The member has progressive or recurrent primary CNS lymphoma and Temodar (temozolomide) is being used as a single agent or in combination with rituximab product. Soft tissue sarcoma: The member has diagnosis of soft tissue sarcoma. Anaplastic Gliomas. The member has diagnosis of Anaplastic Gliomas and Temodar (temozolomide) will be used as monotherapy and one of the following applies: adjuvant treatment or recurrent disease OR Temodar (temozolomide) will be given in combination with bevacizumab product for treatment of recurrent disease.
Part B Prerequisite	0

temsirolimus - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients that have experienced disease progression while on temsirolimus.
Required Medical Information	The member has a diagnosis of advanced/metastatic renal cell carcinoma (stage IV).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

TENORETIC 50 - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TENORMIN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TEPEZZA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Thyroid Eye Disease: has a diagnosis of Thyroid Eye Disease AND is euthyroid or currently receiving treatment to correct the thyroid levels AND Tepezza (teprotumumab) is being prescribed by or in consultation with an ophthalmologist, endocrinologist, specialist or physician who specializes in TED AND the prescriber attests that member has not received prior course of therapy (e.g., 8 infusions per lifetime) AND has moderate to severe Thyroid Eye Disease defined as one of the following: greater than or equal to 2 mm Lid retraction, moderate or severe soft tissue involvement, exophthalmos greater than or equal to 3 mm above normal, Diplopia.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TEPMETKO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member experiences disease progression on MET inhibitor (e.g., Tabrecta, Tepmetko).
Required Medical Information	Non-small cell lung cancer (NSCLC). The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND The disease is documented MET exon 14 skipping positive.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

teriflunomide - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TESTIM - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

testosterone - GEL IN METERED-DOSE PUMP

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

testosterone - GEL IN PACKET (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Metastatic Breast Cancer (testosterone enanthate only) OR Delay Puberty in Males (testosterone enanthate only) OR Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

testosterone cypionate - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Metastatic Breast Cancer (testosterone enanthate only) OR Delay Puberty in Males (testosterone enanthate only) OR Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

testosterone enanthate - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Metastatic Breast Cancer (testosterone enanthate only) OR Delay Puberty in Males (testosterone enanthate only) OR Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tetrabenazine - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of chorea associated with Huntington's disease. For Brand Xenazine: The member must have had previous treatment or intolerance with tetrabenazine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TEVIMBRA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Esophageal squamous cell carcinoma: The member has a diagnosis of unresectable or metastatic esophageal squamous cell carcinoma AND One of the following: Tevimbra (tislelizumab-jsgr) will be used as monotherapy AND the member has received prior systemic chemotherapy that did not include a PD-L1 inhibitor OR The member will be using Tevimbra (tislelizumab-jsgr) as first line therapy AND the tumor expresses PD-L1 (Combined Positive Score (CPS) greater than or equal to 1) AND tevimbra (tislelizumab-jsgr) will be used in combination with platinum-containing chemotherapy, followed by Tevimbra (tislelizumab-jsgr) monotherapy. Gastric or gastroesophageal junction adenocarcinoma: The member has a diagnosis of unresectable or metastatic gastric or gastroesophageal junction adenocarcinoma AND The tumor is HER2-negative and PD-L1 positive (CPS greater than or equal to 1) AND Tevimbra (tislelizumab-jsgr) will be used as first line therapy AND Tevimbra (tislelizumab-jsgr) will be used in combination with platinum and fluoropyrimidine-based chemotherapy, followed by Tevimbra (tislelizumab-jsgr) monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

TEZRULY - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Benign Prostatic Hyperplasia: Diagnosis of benign prostatic hyperplasia AND Member has had previous treatment or intolerance to at least ONE generic alpha-1 blocker (e.g. alfuzosin, doxazosin, prazosin, terazosin). Hypertension: Diagnosis of hypertension AND Member has had previous treatment, intolerance, or contraindication to at least ONE of the following: angiotensin-converting enzyme inhibitor (e.g. lisinopril), angiotensin receptor blocker (e.g. losartan), calcium channel blocker (e.g. amlodipine), or a diuretic (e.g. hydrochlorothiazide) AND Member has had previous treatment or intolerance to at least ONE generic alpha-1 blocker (e.g. alfuzosin, doxazosin, prazosin, terazosin).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TEZSPIRE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Severe Asthma: Member must meet all of the following criteria: diagnosis of severe asthma AND documented history of two or more asthma exacerbations within the past 12 months requiring treatment with systemic corticosteroids or hospitalization AND unable to achieve adequate control of asthma while on maximum tolerated inhaled corticosteroid therapy (e.g. mometasone greater than 400 mcg daily, fluticasone greater than 440 mcg daily) in combination with a long acting beta2 agonist AND Tezspire (tezepelumab-ekko) will not be used in combination with an anti-IgE, anti-IL4, or anti-IL5 agent (eg. Xolair (omalizumab), Dupixent (dupilumab), Nucala (mepolizumab), Fasenra (benralizumab), Cinqair (relizumab)). Chronic Rhinosinusitis with Nasal Polyposis: Diagnosis of Chronic Rhinosinusitis with Nasal Polyposis AND Tezspire (tezepelumab-ekko) will be used in combination with a daily intranasal corticosteroid spray AND Has had previous treatment, contraindication, or intolerance with two of the following: Dupixent, Xolair or Nucala.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

THALOMID - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on thalidomide.
Required Medical Information	Erythema Nodosum Leprosum (ENL). The member is currently having acute cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) OR Thalomid (thalidomide) is prescribed for maintenance therapy for prevention and suppression of the cutaneous manifestations of (ENL) recurrence. Multiple Myeloma. The member has a diagnosis of Multiple Myeloma. Waldenstrom's Macroglobulinemia. The member has a diagnosis of Waldenstrom's macroglobulinemia or lymphoplasmacytic lymphoma AND Thalomid (thalidomide) is being used for primary therapy, progressive or relapsed disease or salvage therapy for disease that does not respond to primary therapy AND Thalomid (thalidomide) is being used as monotherapy or in combination with a rituximab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

THYMOGLOBULIN - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	History of allergy or anaphylaxis to rabbit proteins. Active infections which contraindicate additional immunosuppression
Required Medical Information	Renal Transplant Rejection: The member must have received a renal transplant AND The member must utilize Thymoglobulin (anti-thymocyte globulin [rabbit]) for prophylaxis or treatment of acute renal transplant rejection AND Thymoglobulin will be used in combination with conventional therapy for transplant rejection. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	2 weeks duration
Other Criteria	
Part B Prerequisite	0

THYQUIDITY - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member is using for suppression of benign thyroid nodules and nontoxic diffuse goiter in iodine sufficient patients. Member is using for treatment of hypothyroidism during the recovery phase of subacute thyroiditis.
Required Medical Information	Thyroid Supplementation: The member is using levothyroxine as replacement therapy in primary (thyroidal), secondary (pituitary), tertiary (hypothalamic), congenital or acquired hypothyroidism OR The member is using levothyroxine as an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TIBSOVO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on or following Tibsovo (ivosidenib)
Required Medical Information	Acute Myeloid Leukemia- Relapsed/Refractory: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member has a documented IDH1 mutation AND one of the following applies: The member will be using Tibsovo (ivosidenib) as monotherapy OR the member will be using Tibsovo as a component of repeating the initial successful induction regimen, if late relapse (relapse occurring later than 12 months). Acute Myeloid Leukemia Newly diagnosed: The member has a diagnosis of acute myeloid leukemia (AML) AND the member has newly diagnosed disease AND one of the following applies: the member is not a candidate for intensive induction therapy due to comorbidities OR the member declines intensive induction therapy. The member has a documented IDH1 mutation AND the member will be using Tibsovo as monotherapy or in combination with azactidine. Cholangiocarcinoma: The member has locally advanced or metastatic cholangiocarcinoma AND the disease has documented isocitrate dehydrogenase-1 (IDH1) mutation AND Tibsovo (ivosidenib) will be a subsequent therapy and used as monotherapy. Myelodysplastic syndromes (MDS): The member has a diagnosis of myelodysplastic syndromes AND The member has relapsed or refractory disease AND The member has a documented IDH1 mutation AND The member will be using Tibsovo (ivosidenib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	MDS: Plan year duration. All other indications: 6 Months Duration
Other Criteria	
Part B Prerequisite	0

TIGLUTIK - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS): The member has a diagnosis of amyotrophic lateral sclerosis AND the member has previous treatment AND a documented contraindication to riluzole tablets (e.g. impaired ability to swallow tablets).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TIKOSYN - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TIROSINT-SOL - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member is using for suppression of benign thyroid nodules and nontoxic diffuse goiter in iodine sufficient patients. Member is using for treatment of hypothyroidism during the recovery phase of subacute thyroiditis.
Required Medical Information	Thyroid Supplementation: The member is using levothyroxine as replacement therapy in primary (thyroidal), secondary (pituitary), tertiary (hypothalamic), congenital or acquired hypothyroidism OR The member is using levothyroxine as an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TIVDAK - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Tivdak (tisotumab vedotin-tftv).
Required Medical Information	Recurrent/ Metastatic Cervical Cancer: The member has recurrent or metastatic cervical cancer AND The member experienced disease progression after chemotherapy AND If the disease expresses CPS score of greater than equal to 1 AND The member has a medical reason why Keytruda (pembrolizumab) cannot be initiated as subsequent therapy AND Tivdak (tisotumab vedotin-tftv) is administered as monotherapy as subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TLANDO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TOBI - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with Pseudomonas aeruginosa. For Brand Requests: Prior therapy, intolerance to, or contraindication to generic tobramycin for inhalation. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TOBI PODHALER - CAPSULE, WITH INHALATION DEVICE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with Pseudomonas aeruginosa. For Brand Requests: Prior therapy, intolerance to, or contraindication to generic tobramycin for inhalation. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

tobramycin - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients colonized with Burkholderia cepacia.
Required Medical Information	Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with Pseudomonas aeruginosa. For Brand Requests: Prior therapy, intolerance to, or contraindication to generic tobramycin for inhalation. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

tolcapone - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease: Member has a diagnosis of Parkinson's Disease AND The member is currently taking levodopa/carbidopa and is experiencing symptom fluctuations AND The member has tried or cannot use entacapone and at least one other drug as adjunct therapy for Parkinson's Disease (e.g. pramipexole, ropinirole, selegiline, rasagiline) AND The member will take Tasmar (tolcapone) in combination with levodopa/carbidopa AND Baseline liver function tests have been performed to rule out underlying liver disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TOLSURA - CAPSULE, SOLID DISPERSION

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Onychomycosis
Required Medical Information	Aspergillosis. The member must have a diagnosis of aspergillosis that is either refractory to amphotericin B therapy OR the member is intolerant to amphotericin B therapy. The member has had previous treatment, contraindication, or intolerance to at least one alternative antifungal agent (e.g. generic itraconazole, voriconazole, posaconazole). Blastomycosis. The member must have a diagnosis of blastomycosis. The member has had previous treatment, contraindication, or intolerance to at least one alternative antifungal agent (e.g. generic itraconazole, ketoconazole, fluconazole). Histoplasmosis. The member must have a diagnosis of histoplasmosis. The member has had previous treatment, contraindication, or intolerance to at least one alternative antifungal agent (e.g. generic itraconazole, ketoconazole, fluconazole, posaconazole, voriconazole).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 month duration
Other Criteria	
Part B Prerequisite	0

tolvaptan - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Use in patients with autosomal dominant polycystic kidney disease (ADPKD) outside of FDA-approved REMS.
Required Medical Information	Tolvaptan (generic Samsca) will be used for the treatment of clinically significant hypervolemic or euvoletic hyponatremia AND tolvaptan (generic Samsca) therapy has been initiated in a hospital. For Brand Request: The member must have had prior therapy, intolerance or contraindication to tolvaptan (generic Samsca).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tolvaptan (polycys kidney dis) - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Autosomal Dominant Polycystic Kidney Disease. Has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) AND Must be at risk of rapidly progressive disease (e.g. advanced stage kidney disease according to age, hypertension before age 35, enlarged kidneys) AND Must have CKD stage 2 - 4 AND Medication is being used to slow kidney function decline.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TONMYA - TABLET, SUBLINGUAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Fibromyalgia: Has a diagnosis of fibromyalgia AND has had previous treatment, contraindication, or intolerance to at least TWO of the following: pregabalin (immediate release), duloxetine 20mg, 30mg, or 60 mg (generic Cymbalta), or gabapentin (immediate release).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

topiramate - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention: The member is using topiramate ER capsule (e.g., Trokendi XR, Qudexy XR) for prophylaxis (prevention) of migraine headache AND the member has had previous treatment with immediate release topiramate AND has had previous treatment, intolerance, or contraindication with one of the following: a serotonin and norepinephrine reuptake inhibitor or a tricyclic antidepressant. Epilepsy Adjunct Therapy: Member has a diagnosis of partial-onset (focal) seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS) AND Member will use topiramate ER capsule (e.g., Trokendi XR, Qudexy XR) in combination with at least one other drug for controlling seizures AND member has tried or cannot use immediate-release topiramate tablet or capsule. Epilepsy Monotherapy: Member has a diagnosis of partial-onset (focal) seizures or primary generalized tonic-clonic seizures AND member has tried or cannot use immediate-release topiramate tablet or capsule.
Age Restriction	Migraine - 12 years of age or older, Seizures - Trokendi XR: 6 years of age or older. Seizures - Qudexy XR: 2 years of age or older.
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

topiramate - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prophylaxis: Member is using for prophylaxis of migraine headache AND has had previous treatment with or intolerance to immediate release topiramate tablet or capsule AND has had previous treatment, intolerance, or contraindication with one of the following: a serotonin and norepinephrine reuptake inhibitor or a tricyclic antidepressant. Epilepsy Adjunctive Therapy: Member has a diagnosis of partial-onset (focal) seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS) AND Member will use Eprontia (topiramate) in combination with at least one other drug for controlling seizures AND Member has tried or cannot use immediate-release topiramate tablet or capsule. Epilepsy Monotherapy: Member has a diagnosis of partial-onset (focal) seizures or primary generalized tonic-clonic seizures AND Member has tried or cannot use immediate release topiramate tablet or capsule.
Age Restriction	Migraine Prophylaxis: Member must be 12 years of age or older. Epilepsy indications: Member must be 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TORISEL - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients that have experienced disease progression while on temsirolimus.
Required Medical Information	The member has a diagnosis of advanced/metastatic renal cell carcinoma (stage IV).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

torpenz - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression while on everolimus.
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) with TSC [Adult and Pediatrics]: Member must have an intolerance or contraindication to generic everolimus AND The member has a diagnosis of SEGA associated with tuberous sclerosis complex (TSC) AND The member requires therapeutic intervention but is not a candidate for curative surgical resection. Angiomyolipoma and Tuberous Sclerosis Complex (TSC): Member must have an intolerance or contraindication to generic everolimus AND The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex (TSC) AND Immediate surgery is not required. Metastatic Breast Cancer: Member must have an intolerance or contraindication to generic everolimus AND The member has a diagnosis of hormone receptor (HR) positive and human epidermal growth factor receptor 2 (HER2) negative metastatic disease AND The member has been treated with endocrine therapy (e.g., letrozole, anastrozole) AND The member will use everolimus in combination with exemestane or fulvestrant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TOVIAZ - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRACLEER - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must meet ALL of the following criteria: Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND For Brand Tracleer (tablet or tablet for suspension) and generic bosentan tablet for oral suspension requests: previous treatment, intolerance, or contraindication with bosentan tablet (generic Tracleer).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tranexamic acid - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with acquired defective color vision, since this prohibits measuring one endpoint that should be followed as a measure of toxicity (changes in vision).Members with subarachnoid hemorrhage. Members with active intravascular clotting.
Required Medical Information	Hemophilia-Hemorrhage.Prophylaxis for Tooth extraction.Members with Hemophilia undergoing dental extraction.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	30 day duration
Other Criteria	NA
Part B Prerequisite	0

TRAZIMERA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Herceptin (trastuzumab), Ogivri, Herzuma or Ontruzant requests: member must have an intolerance or contraindication Trazimera (trastuzumab-qyyp) OR Kanjinti (trastuzumab-anns) and meets below criteria: Breast Cancer: The member has a diagnosis of breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive). Gastric Cancer: The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 positive disease (e.g., defined as IHC 3+ or IHC2+/ISH positive) AND trastuzumab is being used in combination with cisplatin and fluorouracil or capecitabine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TREANDA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members who experience disease progression on bendamustine containing regimens.
Required Medical Information	Chronic Lymphocytic Leukemia (CLL). The member has a diagnosis of CLL AND bendamustine is being used for relapsed or refractory disease or as first line therapy. Multiple Myeloma (MM). The member has a diagnosis of MM AND bendamustine is being used for disease relapse or for progressive or refractory disease. Non-Hodgkin's Lymphoma: The member has a diagnosis of follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma or mantle cell lymphoma. The member has a diagnosis of primary cutaneous B-cell lymphoma (primary cutaneous marginal zone or follicle center B-cell lymphoma) and bendamustine is being used as a single agent or in combination with a rituximab product in one of the following: Refractory generalized cutaneous disease OR generalized extracutaneous disease as initial therapy or for relapse. The member has a diagnosis of splenic marginal zone lymphoma and bendamustine is being used as one of the following: First-line therapy for disease progression following initial treatment for splenomegaly OR Second-line or subsequent therapy for progressive disease. The member has a diagnosis of diffuse large B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy. The member has a diagnosis of AIDS-related B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Waldenstroms Macroglobulinemia: The member has Waldenstroms macroglobulinemia or lymphoplasmacytic lymphoma and bendamustine is being used as one of the following: Primary therapy OR Progressive or relapsed disease. Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND bendamustine will be used as subsequent therapy for relapsed or refractory disease.
Part B Prerequisite	0

TRELSTAR - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	Prostate Cancer. The member has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TREMFYA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member must weigh at least 40kg AND the member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member must weigh at least 40kg. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's Disease.
Age Restriction	Plaque Psoriasis, Psoriatic Arthritis: The member must be 6 years of age or older. All other indications: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TREMFYA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's Disease.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TREMFYA ONE-PRESS - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member must weigh at least 40kg AND the member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member must weigh at least 40kg. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's Disease.
Age Restriction	Plaque Psoriasis, Psoriatic Arthritis: The member must be 6 years of age or older. All other indications: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TREMFYA PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member must weigh at least 40kg AND the member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member must weigh at least 40kg. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's Disease.
Age Restriction	Plaque Psoriasis, Psoriatic Arthritis: The member must be 6 years of age or older. All other indications: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TREMFYA PEN INDUCTION PK(2PEN) - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member must weigh at least 40kg AND the member has had prior therapy with or intolerance to a single conventional oral systemic treatment (e.g. methotrexate, cyclosporine), or contraindication to all conventional oral systemic treatments. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND the member must weigh at least 40kg. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's Disease.
Age Restriction	Plaque Psoriasis, Psoriatic Arthritis: The member must be 6 years of age or older. All other indications: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

treprostinil sodium - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND WHO Functional Class II-IV AND Pulmonary hypertension has progressed despite maximal medical and/or surgical treatment AND Member experiences significant symptoms (e.g. dyspnea on exertion, fatigue, angina, syncope) AND Treatment with oral calcium channel blockers has been tried and failed or has been considered and ruled out. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tretinoin - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

tretinoin microspheres - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Approval will be given to all members using this agent for medically necessary, FDA approved, or compendia supported, non-cosmetic indications including but not limited to the following: Acne: the member has a diagnosis of acne vulgaris, Actinic Keratosis: the member has a diagnosis of actinic keratosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRIBENZOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRICOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRIKAFTA - GRANULES IN PACKET, SEQUENTIAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis: The member must meet ALL of the following criteria: Diagnosis of Cystic Fibrosis AND Prior lab testing with documentation of a mutation in the CFTR gene that is responsive to therapy based on clinical literature and/or in vitro assay data.
Age Restriction	
Prescriber Restriction	The member is being treated by or in consultation with a specialist (e.g. pulmonologist).
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRILEPTAL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRILIPIX - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRIPTODUR - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Central Precocious Puberty. The member has a diagnosis of central precocious puberty.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TRISENOX - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Promyelocytic Leukemia (APL). The member has a diagnosis of acute promyelocytic leukemia AND the member will be using Trisenox (arsenic trioxide) for induction therapy, consolidation therapy, or relapsed disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TRODELVY - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members experienced disease progression on Trodelvy (sacituzumab govitecan-hziy)
Required Medical Information	Breast Cancer (Triple Negative): The member has unresectable locally advanced or metastatic triple negative breast cancer AND The member has received at least two prior therapies, where one was administered for metastatic disease AND Trodelvy (sacituzumab govitecan-hziy) is given as single agent as subsequent therapy. Breast cancer (Hormone Receptor (HR)- positive): The member has a diagnosis of unresectable locally advanced or metastatic hormone receptor (HR)- positive, human epidermal growth factor receptor 2 (HER2)-negative (e.g., IHC 0, IHC 1+ or IHC 2+/ISH-) breast cancer AND The member has received endocrine-based therapy AND The member has received at least two additional systemic therapies in the metastatic setting (e.g. taxane) AND Trodelvy will be used as a single agent for subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TROKENDI XR - CAPSULE, EXT RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention: The member is using topiramate ER capsule (e.g., Trokendi XR, Qudexy XR) for prophylaxis (prevention) of migraine headache AND the member has had previous treatment with immediate release topiramate AND has had previous treatment, intolerance, or contraindication with one of the following: a serotonin and norepinephrine reuptake inhibitor or a tricyclic antidepressant. Epilepsy Adjunct Therapy: Member has a diagnosis of partial-onset (focal) seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS) AND Member will use topiramate ER capsule (e.g., Trokendi XR, Qudexy XR) in combination with at least one other drug for controlling seizures AND member has tried or cannot use immediate-release topiramate tablet or capsule. Epilepsy Monotherapy: Member has a diagnosis of partial-onset (focal) seizures or primary generalized tonic-clonic seizures AND member has tried or cannot use immediate-release topiramate tablet or capsule.
Age Restriction	Migraine - 12 years of age or older, Seizures - Trokendi XR: 6 years of age or older. Seizures - Qudexy XR: 2 years of age or older.
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	Plan Year Duration.
Other Criteria	
Part B Prerequisite	0

TRUDHESA - AEROSOL, SPRAY WITH PUMP (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Migraine: Will be using Trudhesa (dihydroergotamine mesylate) for acute treatment of moderate to severe migraine headaches with or without aura AND Has had previous treatment, intolerance, or contraindication to Ubrelvy tablet and ONE of the following agents: naproxen tablet, naratriptan tablet, rizatriptan tablet, sumatriptan tablet.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRULANCE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Idiopathic Constipation: The member must have a diagnosis of chronic idiopathic constipation AND the member has had previous treatment, intolerance, or contraindication to Linzess (linaclotide) and lubiprostone. Irritable Bowel Syndrome with Constipation: The member must have a diagnosis of irritable bowel syndrome with constipation AND the member has had previous treatment, intolerance, or contraindication to Linzess (linaclotide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TRULICITY - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using for weight loss.
Required Medical Information	Diabetes Mellitus. The member has a diagnosis of type 2 diabetes mellitus.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TRUQAP - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has progression while on Truqap (capivasertib).
Required Medical Information	HR-positive/HER2-negative metastatic breast cancer. Member has metastatic or locally advanced breast cancer AND Member has a diagnosis of hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative disease AND Member has one or more documented PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test AND Member has progressed on at least one prior endocrine-based regimens [including one line containing a cyclin-dependent kinase (CDK) 4 and 6 inhibitor (e.g., ribociclib, abemaciclib, palbociclib)] and meets one of the following: Has been treated previously in the metastatic setting OR Has recurrence on or within 12 months of completing adjuvant therapy AND Member will be using Truqap (capivasertib) in combination with fulvestrant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TRUXIMA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Chronic Lymphocytic Leukemia: High dose CLL therapies (doses greater than 500mg/m²). The length of maintenance therapy exceeds 2 years for chronic lymphocytic leukemia. Non-Hodgkin's Lymphoma (CD-20 positive/B-cell): The member will be using rituximab as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma). Waldenstrom's Macroglobulinemia: The length of maintenance therapy exceeds 2 years for low-grade non-Hodgkins lymphoma (e.g. follicular lymphoma, marginal zone lymphoma).
Required Medical Information	For requests for Rituxan or Truxima: member must have intolerance or contraindication with Ruxience or Riabni and meet the criteria below. Chronic Lymphocytic Leukemia. The member has a diagnosis of CLL. Non-Hodgkin's Lymphoma (CD-20 positive/B-Cell). The member has a diagnosis of CD-20 positive/B-cell Non-Hodgkin's lymphoma. Hodgkin's Disease (Hodgkin's Lymphoma). The member has a diagnosis of Hodgkin's Disease. The member will be using rituximab product for primary treatment or for relapsed or progressive disease AND disease has confirmed CD20 positivity. Rheumatoid Arthritis. The member has a diagnosis of moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with, contraindication, or intolerance with one of the following: Remicade, Inflectra, infliximab, or Simponi Aria* (previous treatment with Simponi Aria applies to medical benefit requests only). The member must be on concomitant treatment with methotrexate during rituximab product therapy, unless contraindicated or intolerant to methotrexate.
Age Restriction	Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The member is 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

TRUXIMA - VIAL (ML)

Other Criteria	Waldenström's macroglobulinemia. The member must have a diagnosis of Waldenström's macroglobulinemia. Post-transplant lymphoproliferative disorder. The member has a diagnosis of Post-transplant Lymphoproliferative disease. Immune or Idiopathic Thrombocytopenic Purpura. The member must have a diagnosis of refractory primary immune or idiopathic thrombocytopenic purpura. Member has not had a splenectomy, but has had an insufficient response or is intolerant to corticosteroids, AND immunoglobulins (IVIG), OR has had a splenectomy with an inadequate response or is intolerant to procedure AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Refractory response is characterized as EITHER: Platelet count less than 25,000/microliter OR Active bleeding due to inadequate platelet function. The member must have had an inadequate response to post-splenectomy corticosteroid therapy for four consecutive weeks within the last three months. Diagnosis of Wegener's Granulomatosis OR Microscopic Polyangiitis. Must be taking rituximab product in combination with glucocorticoids. Pemphigus Vulgaris (PV). The member must have a diagnosis of moderate to severe Pemphigus Vulgaris.
Part B Prerequisite	0

TRYNGOLZA - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Familial Chylomicronemia Syndrome (FCS): The member has fasting triglyceride levels greater than or equal to 880 mg/dL prior to Tryngolza (olezarsen) initiation AND The member has a diagnosis of familial chylomicronemia syndrome as defined by at least one of the following: Genetic confirmation demonstrating biallelic pathogenic variants in at least one gene causing FCS: lipoprotein lipase (LPL), apolipoprotein C-II (ApoC2), glycosylphosphatidylinositol-anchored high-density lipoprotein-binding protein 1 (GPIHBP1), apolipoprotein A-V (ApoA5), or lipase maturation factor 1 (LMF1) OR North American FCS score of greater than or equal to 45 OR Familial chylomicronemia syndrome score greater than or equal to 10 OR History of acute pancreatitis OR History of recurrent, unexplained abdominal pain AND The member is on a low-fat diet (less than or equal to 20 g fat per day).
Age Restriction	
Prescriber Restriction	The member is treated by or in consultation with a specialist (e.g. cardiologist, endocrinologist).
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TRYPTYR - DROPPERETTE, SINGLE-USE DROP DISPENSER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dry Eye Disease: Has a diagnosis of dry eye disease AND Has had previous treatment, contraindication, or intolerance to the following: cyclosporine eye drops (generic Restasis), AND Eysuvis (loteprednol).* Previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TRYVIO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Resistant Hypertension: The member has a diagnosis of treatment-resistant hypertension defined as elevated blood pressure despite concurrent use of three or more antihypertensive drug classes AND The member has had previous treatment, intolerance, or contraindication to one mineralocorticoid receptor antagonist (e.g. spironolactone, eplerenone).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TUDORZA PRESSAIR - AEROSOL POWDER, BREATH ACTIVATED (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema. The member has had previous treatment, contraindication, or intolerance to Spiriva (i.e. Spiriva Handihaler, Spiriva Respimat). For Yupelri requests: BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TUKYSA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Tukysa (tucatinib)
Required Medical Information	Breast Cancer. The member has metastatic or advanced unresectable HER 2 positive breast cancer (inclusive of brain metastases) and all of the following apply: Member has received one or more prior anti-HER2 based regimen in the metastatic setting AND Tukysa is given in combination with trastuzumab product and capecitabine as subsequent therapy. Colorectal cancer. The member has a diagnosis of RAS wild-type HER2-positive unresectable or metastatic colorectal cancer AND The member has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy AND Tukysa will be given in combination with trastuzumab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TURALIO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Symptomatic Tenosynovial Giant Cell Tumor: The member has symptomatic tenosynovial giant cell tumor (TGCT) and the disease is associated with severe morbidity or functional limitations and the disease is not amenable to improvement with surgery and Turalio (pexidartinib) will be used as monotherapy.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA
Part B Prerequisite	0

TYENNE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderately to Severely Active Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis AND The member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Systemic Juvenile Idiopathic Arthritis. The member must have a diagnosis of active systemic juvenile idiopathic arthritis (SJIA) or as formerly known, systemic juvenile rheumatoid arthritis. Giant Cell Arteritis: The member must have a diagnosis of giant cell arteritis AND the member has had prior therapy, contraindication, or intolerance with Rinvoq.
Age Restriction	Member must be 18 years and older. For the treatment of PJIA and SJIA the member must be at least 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TYENNE AUTOINJECTOR - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderately to Severely Active Rheumatoid Arthritis: The member must have a diagnosis of moderately to severely active rheumatoid arthritis AND The member has prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Systemic Juvenile Idiopathic Arthritis. The member must have a diagnosis of active systemic juvenile idiopathic arthritis (SJIA) or as formerly known, systemic juvenile rheumatoid arthritis. Giant Cell Arteritis: The member must have a diagnosis of giant cell arteritis AND the member has had prior therapy, contraindication, or intolerance with Rinvoq.
Age Restriction	Member must be 18 years and older. For the treatment of PJIA and SJIA the member must be at least 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

TYKERB - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Tykerb (lapatinib).
Required Medical Information	For brand Tykerb requests: Member must have an intolerance or contraindication to generic lapatinib AND member must meet clinical criteria below. Breast Cancer: The member has a diagnosis of HER2 (human epidermal growth factor receptor2) positive advanced or metastatic breast cancer AND The member had prior therapy, contraindication, or intolerance with an anthracycline (e.g. doxorubicin) and a taxane (e.g. paclitaxel) OR The member has a diagnosis of HER2 positive metastatic breast cancer AND Used as first line treatment in combination with an aromatase inhibitor (Femara/letrozole, Arimidex/anastrozole or Aromasin/exemestane) for hormone receptor positive disease.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

TYMLOS - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Osteoporosis in Postmenopausal Women: The member must have a diagnosis of osteoporosis AND the member must be postmenopausal AND The member must meet one of the following criteria: The member must be at a high risk of fracture defined as a history of osteoporotic fracture or The member has multiple risk factors for fracture (e.g. inflammatory joint disorders, diabetes, hyperthyroidism, liver disease) OR The member has failed or is intolerant to at least ONE other available osteoporosis therapy (e.g. bisphosphates, RANK-ligand inhibitor, parathyroid hormone analog, sclerostin inhibitor, etc.) OR The member must be at VERY HIGH RISK for fracture as defined as: recent fracture (e.g. within the past 12 months) OR fracture while on approved therapy for treatment of osteoporosis OR fracture while on drugs causing skeletal harm (e.g. systemic corticosteroids) OR experienced multiple fractures OR has a very low T-score (e.g. less than -3.0) OR is at high risk for falls or has a history of falls OR has a very high fracture probability per FRAX (e.g. greater than 30% major osteoporotic fracture, greater than 4.5% hip fracture). Osteoporosis in Men: The member must be using for osteoporosis in men AND The member is at high risk of fracture as defined as: a history of osteoporotic fracture OR multiple risk factors for fracture OR The member has new fractures or significant loss of bone mineral density despite previous treatment, contraindication or intolerance with an oral or intravenous bisphosphonate (e.g. alendronate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TYRUKO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis: The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND Natalizumab will be used as monotherapy AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), teriflunomide, or a rituximab product (e.g., Riabni, Ruxience). Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has tried or cannot use: Remicade, Inflectra OR Infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TYRVAYA - SPRAY, METERED, NON-AEROSOL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dry eye disease. Has a diagnosis of dry eye disease AND has had previous treatment, contraindication, or intolerance to the following: cyclosporine eye drops (generic Restasis), AND Eysuvis (loteprednol)*. *Previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TYSABRI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis: The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND Natalizumab will be used as monotherapy AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), teriflunomide, or a rituximab product (e.g., Riabni, Ruxience). Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has tried or cannot use: Remicade, Inflectra OR Infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TYVASO - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must meet ALL of the following criteria: Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND Prior therapy, intolerance or contraindication to an endothelin receptor antagonist (e.g. bosentan, ambrisentan, macitentan) AND Prior therapy, intolerance, or contraindication to a phosphodiesterase type 5 inhibitor approved for use in PAH (e.g. sildenafil, tadalafil) or Adempas (riociguat) AND Will continue one of the following in combination with Tyvaso (treprostinil): endothelin receptor antagonist treatment (e.g., bosentan, ambrisentan, macitentan) OR phosphodiesterase type 5 inhibitor (e.g. sildenafil, tadalafil) OR Adempas (riociguat). Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD): The member meets ALL of the following criteria: Diagnosis of Pulmonary Hypertension associated Interstitial Lung Disease (WHO Group 3) confirmed by both: Right heart catheterization with evidence of pulmonary hypertension AND High Resolution Computer Tomography or Lung Biopsy with evidence of Interstitial Lung Disease. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TYVASO DPI - CARTRIDGE WITH INHALER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must meet ALL of the following criteria: Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND Prior therapy, intolerance or contraindication to an endothelin receptor antagonist (e.g. bosentan, ambrisentan, macitentan) AND Prior therapy, intolerance, or contraindication to a phosphodiesterase type 5 inhibitor approved for use in PAH (e.g. sildenafil, tadalafil) or Adempas (riociguat) AND Will continue one of the following in combination with Tyvaso (treprostinil): endothelin receptor antagonist treatment (e.g., bosentan, ambrisentan, macitentan) OR phosphodiesterase type 5 inhibitor (e.g. sildenafil, tadalafil) OR Adempas (riociguat). Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD): The member meets ALL of the following criteria: Diagnosis of Pulmonary Hypertension associated Interstitial Lung Disease (WHO Group 3) confirmed by both: Right heart catheterization with evidence of pulmonary hypertension AND High Resolution Computer Tomography or Lung Biopsy with evidence of Interstitial Lung Disease. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TYVASO INSTITUTIONAL START KIT - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must meet ALL of the following criteria: Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND Prior therapy, intolerance or contraindication to an endothelin receptor antagonist (e.g. bosentan, ambrisentan, macitentan) AND Prior therapy, intolerance, or contraindication to a phosphodiesterase type 5 inhibitor approved for use in PAH (e.g. sildenafil, tadalafil) or Adempas (riociguat) AND Will continue one of the following in combination with Tyvaso (treprostinil): endothelin receptor antagonist treatment (e.g., bosentan, ambrisentan, macitentan) OR phosphodiesterase type 5 inhibitor (e.g. sildenafil, tadalafil) OR Adempas (riociguat). Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD): The member meets ALL of the following criteria: Diagnosis of Pulmonary Hypertension associated Interstitial Lung Disease (WHO Group 3) confirmed by both: Right heart catheterization with evidence of pulmonary hypertension AND High Resolution Computer Tomography or Lung Biopsy with evidence of Interstitial Lung Disease. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TYVASO REFILL KIT - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must meet ALL of the following criteria: Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND Prior therapy, intolerance or contraindication to an endothelin receptor antagonist (e.g. bosentan, ambrisentan, macitentan) AND Prior therapy, intolerance, or contraindication to a phosphodiesterase type 5 inhibitor approved for use in PAH (e.g. sildenafil, tadalafil) or Adempas (riociguat) AND Will continue one of the following in combination with Tyvaso (treprostinil): endothelin receptor antagonist treatment (e.g., bosentan, ambrisentan, macitentan) OR phosphodiesterase type 5 inhibitor (e.g. sildenafil, tadalafil) OR Adempas (riociguat). Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD): The member meets ALL of the following criteria: Diagnosis of Pulmonary Hypertension associated Interstitial Lung Disease (WHO Group 3) confirmed by both: Right heart catheterization with evidence of pulmonary hypertension AND High Resolution Computer Tomography or Lung Biopsy with evidence of Interstitial Lung Disease. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

TYVASO STARTER KIT - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must meet ALL of the following criteria: Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND Prior therapy, intolerance or contraindication to an endothelin receptor antagonist (e.g. bosentan, ambrisentan, macitentan) AND Prior therapy, intolerance, or contraindication to a phosphodiesterase type 5 inhibitor approved for use in PAH (e.g. sildenafil, tadalafil) or Adempas (riociguat) AND Will continue one of the following in combination with Tyvaso (treprostinil): endothelin receptor antagonist treatment (e.g., bosentan, ambrisentan, macitentan) OR phosphodiesterase type 5 inhibitor (e.g. sildenafil, tadalafil) OR Adempas (riociguat). Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD): The member meets ALL of the following criteria: Diagnosis of Pulmonary Hypertension associated Interstitial Lung Disease (WHO Group 3) confirmed by both: Right heart catheterization with evidence of pulmonary hypertension AND High Resolution Computer Tomography or Lung Biopsy with evidence of Interstitial Lung Disease. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

UBRELVY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Migraine: The member will be utilizing Ubrelvy (ubrogepant) for the acute treatment of migraines AND The member has had previous treatment, intolerance, or contraindication to ONE of the following: naratriptan, rizatriptan, sumatriptan.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

UCERIS - AEROSOL, FOAM WITH APPLICATOR (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Mild to moderate active ulcerative colitis: The member must have a diagnosis of mild to moderate active ulcerative colitis AND the member must have had previous treatment or intolerance to at least two of the following: sulfasalazine, balsalazide capsules, mesalamine enema or mesalamine 0.375g extended-release.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Mild to moderate active ulcerative colitis: The member must have a diagnosis of mild to moderate active ulcerative colitis AND the member must have had previous treatment or intolerance to at least two of the following: sulfasalazine, balsalazide capsules, mesalamine enema or mesalamine 0.375g extended-release.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

UCERIS - AEROSOL, FOAM WITH APPLICATOR (GRAM)

Part B Prerequisite	0

UDENYCA - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Febrile Neutropenia Prophylaxis: Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimens risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.
Part B Prerequisite	0

UDENYCA AUTOINJECTOR - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Febrile Neutropenia Prophylaxis: Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimens risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.
Part B Prerequisite	0

UDENYCA ONBODY - SYRINGE, WITH WEARABLE INJECTOR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Febrile Neutropenia Prophylaxis: Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimens risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.
Part B Prerequisite	0

ULTOMIRIS - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH). Documentation in the medical record supporting the diagnosis of PNH defined as: granulocyte or monocyte clone size of greater than 5% AND Documentation in the medical record of an LDH level of 1.5 times the upper limit of the normal range AND One of the following: Member is transfusion dependent as defined as one of the following: Hemoglobin less than or equal to 7g/dL OR Both of the following: Hemoglobin less than or equal to 9 g/dL, Member is experiencing symptoms of anemia OR Member has a documented history of major adverse vascular events from thromboembolism (e.g., abdominal pain, shortness of breath, chest pain, end organ damage). Atypical Hemolytic Uremic Syndrome (aHUS): Documentation supporting the diagnosis of aHUS by ruling out both of the following: Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS) and Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Generalized Myasthenia Gravis (gMG): The member has a diagnosis of generalized myasthenia gravis AND the presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND the member is being treated by, or under the supervision of, a specialty (e.g. neurologist) experienced in the management of generalized Myasthenia Gravis AND the member has tried or cannot use Vyvgart OR Vyvgart Hytrulo. Neuromyelitis Optica Spectrum Disorder (NMOSD): the member must have at least one of the core clinical characteristics associated with Neuromyelitis Optica Spectrum Disorder (NMOSD) listed below: optic neuritis, acute myelitis, area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions. The member must be anti-aquaporin-4 (AQP4) antibody positive.
Part B Prerequisite	0

umeclidinium-vilanterol - BLISTER, WITH INHALATION DEVICE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema AND the member has had previous treatment, contraindication, or intolerance to Stiolto Respimat AND Spiriva Respimat OR Spiriva Handihaler.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

UNDECATREX - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

UNITUXIN - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members receiving Unituxin (dinutuximab) as monotherapy. Members that have experienced disease progression while on Unituxin (dinutuximab).
Required Medical Information	High-risk neuroblastoma: The member has a diagnosis of high-risk neuroblastoma AND Unituxin (dinutuximab) will be used in combination with isotretinoin AND Unituxin (dinutuximab) will be used in alternating cycles of Leukine (sargramostim) and Proleukin (aldesleukin) AND The member has achieved at least a partial response to the following: Induction combination chemotherapy AND Maximum feasible surgical resection The member has had the previous procedure/therapy: Myeloablative consolidation chemotherapy followed by autologous stem cell transplantation AND Radiation therapy to residual soft tissue disease.
Age Restriction	Member must be 18 years of age or younger.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

UPLIZNA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neuromyelitis Optica Spectrum Disorder (NMOSD): The member must be anti-aquaporin-4 (AQP4) antibody positive AND The member must have at least ONE of the core clinical characteristics associated with Neuromyelitis Optica Spectrum Disorder (NMOSD) listed below: Optic neuritis, Acute myelitis, Area postrema syndrome: Episode of other unexplained hiccups or nausea and vomiting, Acute brainstem syndrome, Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD typical, diencephalic MRI lesions, Symptomatic cerebral syndrome with NMOSD-typical brain lesions. Immunoglobulin (Ig) G4-related disease (IgG4-RD): The member must have a clinical diagnosis of Immunoglobulin (Ig) G4-related disease (IgG4-RD) AND The member must have tried, failed, or cannot use a glucocorticoid (e.g., prednisone, dexamethasone, methylprednisolone). Generalized Myasthenia Gravis (gMG): Anti-AChR Antibody Positive: The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND Is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND Has tried or cannot use: Vyvgart (efgartigimod alfa-fcab) OR Vyvgart Hytrulo (efgartigimod alfa-fcab and hyaluronidase-qvfc). Generalized Myasthenia Gravis (gMG): Anti-MuSK Antibody Positive: The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-muscle specific tyrosine kinase (MuSK) antibodies has been confirmed AND Is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND Has tried or cannot use: Pyridostigmine AND At least one immunosuppressive therapy (e.g. azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	

UPLIZNA - VIAL (ML)

Part B Prerequisite	0

UPTRAVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization. The member must have had prior therapy, intolerance to, or contraindication to: ONE Endothelin receptor antagonist (e.g., ambrisentan, bosentan, macitentan).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

URSO FORTE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ursodiol - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Gallstone Treatment: Member is using Reltone (ursodiol) to treat radiolucent, noncalcified gallstones AND has had previous treatment or intolerance with generic ursodiol tablets or 300 mg capsules. Gallstone Prevention: Member is using Reltone (ursodiol) to prevent gallstone formation during rapid weight loss AND has had previous treatment or intolerance with generic ursodiol tablets or 300 mg capsules.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

USTEKINUMAB - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis (SC formulation only): The member must have a diagnosis of moderate to severe chronic plaque psoriasis AND The member has had prior therapy or intolerance to one or more oral systemic treatments (e.g. methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Psoriatic arthritis (SC formulation only): The member must have a diagnosis of active psoriatic arthritis. Moderately to severely active Crohn's disease (IV and SC formulations). The member must have a diagnosis of moderately to severely active Crohn's disease. Moderate to severely active ulcerative colitis (IV and SC formulations): The member must have a diagnosis of moderately to severely active ulcerative colitis.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

USTEKINUMAB-AEKN - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

USTEKINUMAB-TTWE - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

USTEKINUMAB-TTWE - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND the member has had prior therapy, contraindication, or intolerance with Remicade OR Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VABRINTY (3 MONTH) - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VABRINTY (4 MONTH) - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VABRINTY (6 MONTH) - SYRINGE (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concomitant use with other luteinizing hormone-releasing hormone (LHRH) analogs.
Required Medical Information	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VAGIFEM - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VALCHLOR - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Valchlor (mechlorethamine).
Required Medical Information	Cutaneous T-Cell Lymphoma: The member has a diagnosis of fungoides-type cutaneous T-cell lymphoma AND The member has had prior therapy with skin-directed therapy or using as primary treatment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VALCYTE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VALIUM - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

valrubicin - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has an active urinary tract infection (UTI). The member has perforated bladder or compromised bladder mucosa. The member has small bladder capacity (unable to tolerate a 75 mL instillation).
Required Medical Information	Bladder Cancer: The member has recurrent or persistent carcinoma in situ of the urinary bladder(Cis). The member has experienced disease progression, intolerance or has a contraindication to BCG therapy. The member is not a candidate for immediate cystectomy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VALSTAR - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has an active urinary tract infection (UTI). The member has perforated bladder or compromised bladder mucosa. The member has small bladder capacity (unable to tolerate a 75 mL instillation).
Required Medical Information	Bladder Cancer: The member has recurrent or persistent carcinoma in situ of the urinary bladder(Cis). The member has experienced disease progression, intolerance or has a contraindication to BCG therapy. The member is not a candidate for immediate cystectomy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VALTREX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VANCOCIN - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VANFLYTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on or following Vanflyta (quizartinib).
Required Medical Information	Acute Myeloid Leukemia (newly diagnosed). The member has newly diagnosed acute myeloid leukemia (AML) AND The member has documented FLT3 internal tandem duplication (ITD)-positive disease AND The member will be using Vanflyta (quizartinib) in combination with standard cytarabine and anthracycline induction and cytarabine consolidation chemotherapy OR The member will be using Vanflyta (quizartinib) as maintenance monotherapy following consolidation with systemic chemotherapy (excludes maintenance monotherapy following allogeneic hemopoietic stem cell transplantation).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VANRAFIA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary immunoglobulin A nephropathy (IgAN): The member has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy AND Vanrafia is being used to reduce proteinuria in adults at risk of rapid disease progression, e.g., a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5g/g AND One of the following applies to the member: The member has tried and failed a maximally tolerated angiotensin-converting enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB) or The member has an intolerance or contraindication to all angiotensin-converting enzyme inhibitors (ACEi) or angiotension II receptor blockers (ARB) AND The member is at high risk of CKD progression despite optimized supportive care (e.g., blood pressure management, lifestyle modification).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VARIZIG - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Varicella Zoster: The member is using Varizig (varicella zoster immune globulin) for post-exposure prophylaxis of varicella zoster. The member is at high risk for the development of varicella zoster infection. High risk individuals include: Immunocompromised children and adults. Newborns of mothers with varicella shortly before or after delivery. Premature infants. Neonates and infants less than one year of age. Adults without evidence of immunity. Pregnant members.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VARUBI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concurrent use with IV Emend, oral Emend (if taking the 150mg dose), Akynzeo, or Cinvanti.
Required Medical Information	Prophylaxis of chemotherapy-induced nausea and vomiting: Member has failed to achieve control of nausea and/or vomiting with aprepitant at the FDA indicated dose OR has a contraindication to aprepitant OR has experienced significant side effects necessitating alternative therapies AND Member must be on concomitant corticosteroid (e.g., dexamethasone), and a 5HT3 antagonist (e.g., ondansetron, dolasetron, palonosetron, or granisetron) unless there is a contraindication AND Varubi (rolapitant) will be used in conjunction with highly emetogenic cancer chemotherapy (HEC) or moderately emetogenic cancer chemotherapy (MEC). Criteria does not apply to requests for the IV formulation of Varubi. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VASOTEC - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VECTIBIX - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with colorectal cancer (CRC) in which RAS mutation status is unknown. Member has disease progression on Vectibix or Erbutux.
Required Medical Information	Colorectal Cancer [Wild-Type RAS; Wild-Type KRAS/NRAS]: The member has a diagnosis of advanced or metastatic colorectal cancer (mCRC) AND The member has colorectal cancer that is documented as wild-type, non-mutated KRAS and NRAS [wild-type RAS] AND one of the criteria following applies: Vectibix (panitumumab) will be used as monotherapy in members who had disease progression on or following fluoropyrimidine (e.g., capecitabine, fluorouracil), oxaliplatin, and irinotecan-containing chemotherapy regimens . OR Vectibix (panitumumab) will be used in combination with CAPEOX, FOLFOX or FOLFIRI OR Vectibix (panitumumab) will be used concurrently with irinotecan-based therapy. Colorectal Cancer [KRAS G12C-mutated]: The member has a diagnosis of metastatic colorectal cancer (mCRC) AND The colorectal cancer is documented as KRAS G12C-mutated, as determined by an FDA-approved test AND The member has received prior systemic treatment with chemotherapy [fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine), oxaliplatin, irinotecan] AND Vectibix (panitumumab) will be given in combination with Lumakras (sotorasib).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VEGZELMA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Malignant Pleural Mesothelioma, Soft Tissue Sarcoma, Recurrent Primary CNS Tumor (including Glioblastoma multiforme), Renal Cell Carcinoma, Non-small cell lung cancer (non-squamous cell histology): The member has experienced disease progression while on or following a bevacizumab product. Metastatic colorectal cancer: A bevacizumab product may not be used in conjunction with Vectibix (panitumumab) or Erbitux (cetuximab).
Required Medical Information	For Avastin (bevacizumab), Alymsys (bevacizumab-maly), Jobevne (bevacizumab-nwgd), and Vegzelma (bevacizumab-adcd) oncology requests: member must have an intolerance or contraindication with Mvasi or Zirabev. Metastatic colorectal cancer: metastatic colorectal cancer AND 1 of the following applies: using a bevacizumab product in combo with fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemo for 1st or 2nd-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemo for 2nd-line therapy in patients who have progressed on 1st-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). NSCLC with non-squamous cell histology AND the disease is unresectable, locally advanced, recurrent, or metastatic AND A bevacizumab product will be used as part of a supported combination chemotherapy. Hepatocellular carcinoma: unresectable or metastatic HCC AND a bevacizumab product will be used as 1st line therapy in combo with an atezolizumab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

VEGZELMA - VIAL (ML)

Other Criteria	Renal cell carcinoma: Member has RCC and a bevacizumab product will be used in combo with interferon alpha. Recurrent Primary CNS Tumor (including Glioblastoma multiforme): Diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND a bevacizumab product is being used as a single agent or in combo with irinotecan, carmustine, lomustine or temozolomide AND the member does not have a CNS hemorrhage. Soft Tissue Sarcoma: One of the following applies: Diagnosis of angiosarcoma AND a bevacizumab product is being used as a single agent OR The member has a diagnosis of solitary fibrous tumor and a bevacizumab product is being used in combo with temozolomide. Macular Retinal Edema. Avastin is being used to treat central or branch retinal vein occlusion with macular retinal edema. Cervical Cancer: member has recurrent, or metastatic cervical cancer AND A bevacizumab product will be used as part of a supported combination therapy. Endometrial Cancer: The member has a diagnosis of endometrial cancer AND One of the following applies: The member has stage III-IV disease or recurrent disease AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, followed by maintenance with a bevacizumab product maintenance OR The member has recurrent disease AND a bevacizumab product monotherapy will be used as second-line or subsequent therapy if not previously used. Malignant Pleural Mesothelioma. Diagnosis of unresectable malignant pleural mesothelioma and a bevacizumab product will be used in combo with cisplatin and pemetrexed or carboplatin and pemetrexed followed by maintenance with a bevacizumab product (for responders). Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer AND One of the following applies: The disease is recurrent, platinum-resistant AND a bevacizumab product will be used in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan AND the member has not received more than 2 prior chemotherapy regimens OR The disease is recurrent, platinum-sensitive AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, or in combination with carboplatin and gemcitabine, followed by a bevacizumab product monotherapy AND The disease is stage III or IV AND initial surgical resection was completed AND a bevacizumab product will be used in combo with carboplatin and paclitaxel, followed by a bevacizumab product monotherapy OR . Age Related Macular Degeneration (Avastin requests only): Avastin (bevacizumab) is being used to treat age related macular degeneration. Diabetic Macular Edema (Avastin requests only): Avastin (bevacizumab) is being used to treat diabetic macular edema.
Part B Prerequisite	0

VELCADE - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on bortezomib.
Required Medical Information	Mantle Cell Lymphoma (MCL): The member has a diagnosis of Mantle Cell Lymphoma(MCL). Multiple Myeloma. The member has a diagnosis of Multiple Myeloma. Waldenström's Macroglobulinemia. The member has a diagnosis of Waldenström's macroglobulinemia AND Velcade (bortezomib) is being used for primary therapy, progressive or relapsed disease or salvage therapy for disease that does not respond to primary therapy AND Velcade (bortezomib) is being used as monotherapy, in combination with Dexamethasone, or in combination with a rituximab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VELETRI - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Heart failure caused by reduced left ventricular ejection fraction.
Required Medical Information	Pulmonary Arterial Hypertension (PAH): Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND WHO Functional Class II-IV AND Pulmonary hypertension has progressed despite maximal medical and/or surgical treatment AND Member experiences significant symptoms (e.g. dyspnea on exertion, fatigue, angina, syncope) AND Treatment with oral calcium channel blockers has been tried and failed or has been considered and ruled out. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VELSIPITY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had previous treatment, contraindication, or intolerance with two of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya.
Age Restriction	18 years of age or older
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VELTASSA - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hyperkalemia: Member is using for hyperkalemia AND The member has discontinued NSAIDs and has persistent hyperkalemia or member is not on NSAID therapy AND The member has discontinued or reduced dose of ACE inhibitor, ARB, or aldosterone antagonist and has persistent hyperkalemia or the member is not on ACE inhibitor, ARB, or aldosterone antagonist therapy AND The member has initiated or adjusted loop diuretic therapy OR loop diuretics are not appropriate for the member AND The member has had previous treatment, intolerance to, or contraindication to Lokelma.
Age Restriction	The member must be 12 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VELTIN - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VENCLEXTA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Venclexta (venetoclax).
Required Medical Information	Chronic Lymphocytic Leukemia (CLL): The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) and one of the following applies: The member has received at least one prior therapy OR The request is for first-line therapy AND the member is using Venclexta (venetoclax) as part of a supported combination therapy. Mantle Cell Lymphoma: The member has a diagnosis of MCL AND one of the following applies: the member is using Venclexta (venetoclax) as second or subsequent line therapy AND the member is using Venclexta (venetoclax) as monotherapy or in combination with a rituximab product or in combination with Imbruvica (ibrutinib) OR The member has untreated, TP53 mutated disease AND the member is using Venclexta (venetoclax) in combination with Brukinsa (zanubrutinib) and Gazyva (obinutuzumab). Acute Myeloid Leukemia: The member has a diagnosis of acute myeloid leukemia (AML) AND one of the following applies: the disease is newly diagnosed AND the member is 75 years or older AND the member will be using Venclexta (venetoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine OR the disease is newly diagnosed AND the member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2-3, severe cardiac or pulmonary comorbidity, moderate hepatic impairment, or creatinine clearance less than 45 ml/min) AND the member will be using Venclexta (venetoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine OR The member has relapsed/refractory disease AND Venclexta (venetoclax) will be used as part of supported combination therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VENCLEXTA STARTING PACK - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Venclexta (venetoclax).
Required Medical Information	Chronic Lymphocytic Leukemia (CLL):The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) and one of the following applies: The member has received at least one prior therapy OR The request is for first-line therapy AND the member is using Venclexta (venetoclax) as part of a supported combination therapy. Mantle Cell Lymphoma: The member has a diagnosis of MCL AND one of the following applies: the member is using Venclexta (venetoclax) as second or subsequent line therapy AND the member is using Venclexta (venetoclax) as monotherapy or in combination with a rituximab product or in combination with Imbruvica (ibrutinib) OR The member has untreated, TP53 mutated disease AND the member is using Venclexta (venetoclax) in combination with Brukinsa (zanubrutinib) and Gazyva (obinutuzumab). Acute Myeloid Leukemia: The member has a diagnosis of acute myeloid leukemia (AML) AND one of the following applies: the disease is newly diagnosed AND the member is 75 years or older AND the member will be using Venclexta (venetoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine OR the disease is newly diagnosed AND the member has comorbidities that preclude the use of intensive induction chemotherapy (e.g. baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2-3, severe cardiac or pulmonary comorbidity, moderate hepatic impairment, or creatinine clearance less than 45 ml/min) AND the member will be using Venclexta (venetoclax) in combination with azacitidine, or decitabine, or low-dose cytarabine OR The member has relapsed/refractory disease AND Venclexta (venetoclax) will be used as part of supported combination therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VENTAVIS - AMPUL FOR NEBULIZATION (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH):The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization with WHO/NYHA Function Class III-IV symptoms OR the member must have had prior therapy, intolerance to, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (e.g., sildenafil or tadalafil) or Adempas (riociguat) AND ONE Endothelin receptor antagonist [e.g., ambrisentan, bosentan, macitentan) AND The member has had prior therapy, intolerance, or contraindication to Tyvaso DPI (treprostinil) OR Uptravi (selexipag). BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VEOPOZ - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	CD55-deficient protein-losing enteropathy (PLE) or CHAPLE disease: Member has a clinical diagnosis of CHAPLE disease and confirmed CD55 loss of function mutation by genetic testing.
Age Restriction	Member is 1 year of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VEOZAH - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe vasomotor symptoms associated with menopause: The member has a diagnosis of moderate to severe vasomotor symptoms associated with menopause AND The member has previous treatment, contraindication, or intolerance to a menopausal hormone therapy product (e.g. estradiol tablet/patch, estradiol-norethindrone acetate tablets) OR a SSRI (e.g. citalopram, fluoxetine, paroxetine) or SNRI (e.g. venlafaxine, desvenlafaxine).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VERELAN PM - CAPSULE,24HR EXTENDED RELEASE PELLET CT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VERKAZIA - DROPPERETTE, SINGLE-USE DROP DISPENSER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Vernal Keratoconjunctivitis (VKC): diagnosis of vernal keratoconjunctivitis (VKC) AND has had previous treatment, contraindication, or intolerance to at least two of the following agents: cromolyn eye drops, dexamethasone sodium phosphate eye drops, prednisolone acetate eye drop suspension, fluorometholone eye drops suspension.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VERQUVO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Heart Failure: The member must meet ALL of the following criteria: Diagnosis of symptomatic chronic heart failure (e.g. NYHA Class II-IV) AND Left ventricular ejection fraction less than or equal to 45% AND Worsening cardiac event resulting in hospitalization or use of IV diuretics within the past six months.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VERSACLOZ - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must be using clozapine ODT or Versacloz (clozapine oral solution) for treatment-resistant schizophrenia. The member must have had prior therapy or intolerance to generic clozapine tablets.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VERZENIO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on CDK 4/6 inhibitor (e.g., palbociclib, ribociclib). Member exceeds two years of total Verzenio (abemaciclib) based treatment (applicable only to early breast cancer).
Required Medical Information	Metastatic Breast cancer- initial endocrine based therapy. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND Verzenio (abemaciclib) is given in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine based therapy. Metastatic breast cancer combination therapy with Faslodex (fulvestrant). The member has diagnosis of advanced or metastatic hormone receptor (HR) positive human epidermal growth factor receptor 2 (HER2) negative breast cancer AND The member has experienced disease progression on endocrine therapy (e.g., anastrozole) AND Verzenio (abemaciclib) is given in combination with Faslodex (fulvestrant). Metastatic breast cancer monotherapy: The member has diagnosis of advanced or metastatic HR positive, HER2 negative breast cancer AND the member has experienced disease progression on endocrine therapy (e.g., anastrozole) and chemotherapy in the metastatic setting AND Verzenio (abemaciclib) is being used as monotherapy. Early Breast cancer - combination therapy: The member has a diagnosis of HR positive, HER2 negative, node positive, early breast cancer at high risk of recurrence AND Verzenio (abemaciclib) is given in combination with tamoxifen or aromatase inhibitor.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

VESICARE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Overactive Bladder (for Vesicare tablet only): The member has a diagnosis of overactive bladder that is not due to neurogenic detrusor overactivity AND the member has had previous treatment, contraindication, or intolerance with two of the following: Oxybutynin immediate-release tablet, oxybutynin extended-release tablet, solifenacin, Myrbetriq, or Gemtesa. Neurogenic detrusor overactivity (Vesicare LS only): The member has a diagnosis of neurogenic detrusor overactivity. The member has had previous treatment, contraindication, or intolerance with both Oxybutynin immediate-release tablet or oxybutynin extended-release AND Myrbetriq OR The member is less than 3 years of age.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VESICARE LS - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Overactive Bladder (for Vesicare tablet only): The member has a diagnosis of overactive bladder that is not due to neurogenic detrusor overactivity AND the member has had previous treatment, contraindication, or intolerance with two of the following: Oxybutynin immediate-release tablet, oxybutynin extended-release tablet, solifenacin, Myrbetriq, or Gemtesa. Neurogenic detrusor overactivity (Vesicare LS only): The member has a diagnosis of neurogenic detrusor overactivity. The member has had previous treatment, contraindication, or intolerance with both Oxybutynin immediate-release tablet or oxybutynin extended-release AND Myrbetriq OR The member is less than 3 years of age.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VEVYE - DROPS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dry Eye Disease (DED): Has a diagnosis of dry eye disease AND has had previous treatment, contraindication, or intolerance to the following: cyclosporine eye drops (generic Restasis), AND Eysuvis (loteprednol). Previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

V-GO 20 - EACH

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	A bolus insulin requirement of less than 2 units.
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of diabetes mellitus AND The member is insulin dependent AND The member does not require more than 40 units of basal insulin daily AND The member has a total daily dose (TDD) of insulin requirement between 20 and 76 units per day AND The member does not require more than 36 units of bolus insulin daily AND The member will use only a compatible insulin (e.g. Novolog/Humalog) in the V-GO device AND All other insulin products will be discontinued upon initiation of the V-GO AND The member was unable to achieve treatment goals (e.g. A1C target) with at least a 3 month trial of Omnipod Products (e.g. Omnipod 5) AND CeQur Simplicity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

V-GO 30 - EACH

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	A bolus insulin requirement of less than 2 units.
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of diabetes mellitus AND The member is insulin dependent AND The member does not require more than 40 units of basal insulin daily AND The member has a total daily dose (TDD) of insulin requirement between 20 and 76 units per day AND The member does not require more than 36 units of bolus insulin daily AND The member will use only a compatible insulin (e.g. Novolog/Humalog) in the V-GO device AND All other insulin products will be discontinued upon initiation of the V-GO AND The member was unable to achieve treatment goals (e.g. A1C target) with at least a 3 month trial of Omnipod Products (e.g. Omnipod 5) AND CeQur Simplicity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

V-GO 40 - EACH

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	A bolus insulin requirement of less than 2 units.
Required Medical Information	Diabetes Mellitus: The member has a diagnosis of diabetes mellitus AND The member is insulin dependent AND The member does not require more than 40 units of basal insulin daily AND The member has a total daily dose (TDD) of insulin requirement between 20 and 76 units per day AND The member does not require more than 36 units of bolus insulin daily AND The member will use only a compatible insulin (e.g. Novolog/Humalog) in the V-GO device AND All other insulin products will be discontinued upon initiation of the V-GO AND The member was unable to achieve treatment goals (e.g. A1C target) with at least a 3 month trial of Omnipod Products (e.g. Omnipod 5) AND CeQur Simplicity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VIBERZI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Patients without a gallbladder OR Alcoholism, alcohol abuse, alcohol addiction, or drink more than 3 alcoholic beverages per day.
Required Medical Information	The member must have a diagnosis of irritable bowel syndrome with diarrhea AND The member has had previous treatment with, contraindication, or intolerance to at least two of the following: loperamide, a tricyclic antidepressant (e.g. amitriptyline, nortriptyline, imipramine HCl, desipramine), or Xifaxan.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VICTOZA 2-PAK - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using for weight loss.
Required Medical Information	Diabetes Mellitus. The member has a diagnosis of type 2 diabetes mellitus AND Previous treatment with, contraindication to, or intolerance with TWO of the following: Mounjaro, Ozempic, Rybelsus, or Trulicity. Previous treatment requirement does not apply to liraglutide requests for pediatric members (10 to 17 years of age).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VICTOZA 3-PAK - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using for weight loss.
Required Medical Information	Diabetes Mellitus. The member has a diagnosis of type 2 diabetes mellitus AND Previous treatment with, contraindication to, or intolerance with TWO of the following: Mounjaro, Ozempic, Rybelsus, or Trulicity. Previous treatment requirement does not apply to liraglutide requests for pediatric members (10 to 17 years of age).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VIDAZA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Myelodysplastic Syndromes. The member has a diagnosis of myelodysplastic syndrome AND one of the following scenarios apply: The member has a Revised International Prognostic Scoring System (IPSS-R) of higher risk disease (i.e. intermediate, high, very high) OR The member has a Revised International Prognostic Scoring System (IPSS-R) of lower risk disease (i.e. very low, low, or intermediate) AND one of the following sets of criteria applies: Clinically relevant thrombocytopenia, neutropenia, or increased marrow blasts OR Member has symptomatic anemia AND No 5q deletion AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND Serum erythropoietin levels less than or equal to 500 mU/mL AND An inadequate response to erythropoietins alone or in combination with Revlimid (lenalidomide) AND An inadequate response or intolerance or contraindication to immunosuppressive therapy OR Member has Symptomatic anemia AND 5q deletion AND An inadequate response or intolerance to Revlimid (lenalidomide) AND Serum erythropoietin levels greater than 500 mU/mL AND An inadequate response or intolerance or contraindication to immunosuppressive therapy. Myeloproliferative Neoplasms: The member has a diagnosis of myelofibrosis (MF)-accelerated phase or MF-blast phase/acute myeloid leukemia. Acute Myelogenous Leukemia (AML). The member has a diagnosis of AML.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

vigabatrin - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Refractory Complex Partial Seizure: Member has a diagnosis of refractory complex partial seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling complex partial seizures (e.g. levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine) AND vigabatrin will be used in combination with at least one other drug for controlling complex partial seizures. Infantile Spasms: Documented diagnosis of infantile spasms.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

vigadrone - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Refractory Complex Partial Seizure: Member has a diagnosis of refractory complex partial seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling complex partial seizures (e.g. levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine) AND vigabatrin will be used in combination with at least one other drug for controlling complex partial seizures. Infantile Spasms: Documented diagnosis of infantile spasms.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VIGAFYDE - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Infantile Spasms: The member has a documented diagnosis of infantile spasms.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VIGAMOX - DROPS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

vigpoder - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Refractory Complex Partial Seizure: Member has a diagnosis of refractory complex partial seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling complex partial seizures (e.g. levetiracetam, topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine) AND vigabatrin will be used in combination with at least one other drug for controlling complex partial seizures. Infantile Spasms: Documented diagnosis of infantile spasms.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VIIBRYD - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Major depressive disorder: The member has a clinical diagnosis of major depressive disorder (MDD) as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D) AND The member must have a documentation of prior therapy, intolerance, or contraindication to a selective serotonin reuptake inhibitor (SSRI) AND a generic bupropion product (75mg/100mg IR, 100mg/150mg/200mg SR, or 150mg/300mg XL) or mirtazapine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VIJOICE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Severe Manifestations of PROS who require systemic therapy: the member has a diagnosis of PIK3CA-related overgrowth spectrum (PROS) AND the member has confirmed mutation in the PIK3CA AND disease manifestations have been assessed as being severe of life threatening, and requiring systemic therapy, as determined by the treating physician.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

vilazodone - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Major depressive disorder: The member has a clinical diagnosis of major depressive disorder (MDD) as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D) AND The member must have a documentation of prior therapy, intolerance, or contraindication to a selective serotonin reuptake inhibitor (SSRI) AND a generic bupropion product (75mg/100mg IR, 100mg/150mg/200mg SR, or 150mg/300mg XL) or mirtazapine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VIMOVO - TABLET,IMMEDIATE,DELAY RELEASE,BIPHASE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, or juvenile idiopathic arthritis (JIA): The member will be using Vimovo for the relief of signs and symptoms of rheumatoid arthritis, osteoarthritis, or ankylosing spondylitis, or for juvenile idiopathic arthritis (JIA) in adolescent members AND member has had prior treatment with two combinations of a prescription strength NSAID taken with proton pump inhibitor (PPI).
Age Restriction	Member is 12 years of age and older and weighs at least 38 kg (83 pounds).
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VIMPAT - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VITRAKVI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Solid Tumors. Member has been diagnosed with advanced or metastatic solid tumor OR Member is not a candidate for surgical resection AND Member has a documented neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known resistance mutation AND Member is not a candidate for or does not have alternative systemic therapy treatment options.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VIVIMUSTA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members who experience disease progression on bendamustine containing regimens.
Required Medical Information	Chronic Lymphocytic Leukemia (CLL). The member has a diagnosis of CLL AND bendamustine is being used for relapsed or refractory disease or as first line therapy. Multiple Myeloma (MM). The member has a diagnosis of MM AND bendamustine is being used for disease relapse or for progressive or refractory disease. Non-Hodgkin's Lymphoma: The member has a diagnosis of follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma or mantle cell lymphoma. The member has a diagnosis of primary cutaneous B-cell lymphoma (primary cutaneous marginal zone or follicle center B-cell lymphoma) and bendamustine is being used as a single agent or in combination with a rituximab product in one of the following: Refractory generalized cutaneous disease OR generalized extracutaneous disease as initial therapy or for relapse. The member has a diagnosis of splenic marginal zone lymphoma and bendamustine is being used as one of the following: First-line therapy for disease progression following initial treatment for splenomegaly OR Second-line or subsequent therapy for progressive disease. The member has a diagnosis of diffuse large B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy. The member has a diagnosis of AIDS-related B-cell lymphoma and bendamustine is being used as second-line therapy or subsequent therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	Waldenstroms Macroglobulinemia: The member has Waldenstroms macroglobulinemia or lymphoplasmacytic lymphoma and bendamustine is being used as one of the following: Primary therapy OR Progressive or relapsed disease. Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND bendamustine will be used as subsequent therapy for relapsed or refractory disease.
Part B Prerequisite	0

VIZIMPRO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer (NSCLC). The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND the following criteria applies: The member has a documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation AND The member is using Vizimpro (dacomitinib) as a single agent for first line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six month duration
Other Criteria	
Part B Prerequisite	0

VOGELXO - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VONJO - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Vonjo (pacritinib).
Required Medical Information	Myelofibrosis: The member has a diagnosis of primary myelofibrosis or secondary myelofibrosis (i.e. post-polycythemia vera or post-essential thrombocythemia) AND The member has one of the following risk categories, as defined by accepted risk stratification tools for myelofibrosis (e.g. International Prognostic Scoring System (IPSS), Dynamic International Prognostic Scoring System (DIPSS), or DIPSS-PLUS): Intermediate-risk disease OR High-risk disease AND The member will be using Vonjo (pacritinib) as monotherapy AND The member has a platelet count below 50 X 10 ⁹ /L.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VOQUEZNA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Erosive Esophagitis - Initial: The member has a diagnosis of erosive esophagitis (EE) AND The diagnosis of EE has been confirmed by endoscopy AND The member has had at least an 8-week trial of empiric proton pump inhibitor (PPI) therapy, and: Symptoms (e.g., heartburn, regurgitation) remain uncontrolled OR Symptoms returned after the PPI was stopped AND Voquezna (vonoprazan) is being prescribed by or in consultation with a provider experienced in the management of EE (e.g., gastroenterologist) AND The provider attests that Voquezna (vonoprazan) will be given for 8 weeks to achieve healing of EE, and if maintenance therapy is needed after healing, Voquezna (vonoprazan) will be given for no more than 6 additional months. Continuation: The provider attests that the member has not received more than 8 total months of treatment with Voquezna (vonoprazan). Helicobacter pylori (H. pylori) Infection: The member has tested positive for Helicobacter pylori (H. pylori) infection AND Voquezna (vonoprazan) will be prescribed in combination with amoxicillin OR amoxicillin and clarithromycin AND The member has tried or cannot use Talicia. Non-erosive gastroesophageal reflux disease: The member has a diagnosis of non-erosive gastroesophageal reflux disease with heartburn as the predominant symptom AND the member experienced heartburn onset at least 6 months prior to starting Voquezna AND the member experiences heartburn 4 or more days per week AND the provider attests that Voquezna will be given for no more than 4 weeks AND the member must have documentation of prior therapy, intolerance, or contraindication to at least two proton pump inhibitors (e.g., omeprazole, pantoprazole).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial and continuation: Plan year duration
Other Criteria	
Part B Prerequisite	0

VORANIGO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members have experienced disease progression while on Voranigo (vorasidenib).
Required Medical Information	Gliomas: The member has a diagnosis of grade 2 astrocytoma or oligodendroglioma AND The member has a documented isocitrate dehydrogenate-1 (IDH1) or isocitrate dehydrogenate-2 (IDH2) mutation AND The member is using Voranigo (vorasidenib) as single agent following surgery (i.e., biopsy, sub-total resection, or gross total resection).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VOSEVI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Retreatment of Chronic Hepatitis C. The member must have a diagnosis of chronic hepatitis C (HCV). Member must be non-cirrhotic OR have compensated cirrhosis (Child-Pugh Class A). The member has relapsed after completing a full course of or has a contraindication to Epclusa. (Note: Previous treatment with Epclusa does not apply if member has had prior treatment failure with a full course of glecaprevir/pibrentasvir therapy).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	
Part B Prerequisite	0

VOTRIENT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on previous pazopanib therapy.
Required Medical Information	Advanced Renal Cell Carcinoma RCC).The member has a diagnosis of advanced renal cell carcinoma (stage IV). First-line therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology OR as subsequent therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology in members who have progressed on prior first-line therapy.Soft Tissue Sarcoma. The member has a diagnosis of soft tissue sarcoma AND The member has progressed after prior chemotherapy. Thyroid Carcinoma: The member has a diagnosis of advanced or metastatic radio-iodine refractory follicular carcinoma, oncocytic cell carcinoma, papillary OR the member has a diagnosis of advanced medullary carcinoma and has disease progression on or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Ovarian Cancer. The member has a diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer. Uterine Neoplasms. The member has a diagnosis of stage II, III, IV, or advanced metastatic uterine neoplasm sarcoma and disease is not suitable for primary surgery AND Votrient (pazopanib) will be used as a single agent.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VOWST - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Prevention of recurrent Clostridioides difficile infection (CDI): Member has experienced at least one episode of Clostridioides difficile infection (CDI) and Vowst will be used to prevent recurrence of CDI AND Member has completed OR will complete CDI standard of care treatment (defined as 10-21 days of treatment with vancomycin 125 mg PO QID and/or fidaxomicin 200 mg PO BID) within 2-4 days before initiating Vowst AND Member will perform a bowel cleanse using magnesium citrate or polyethylene glycol electrolyte solution on the day prior to first dose of Vowst.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VOXZOGO - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Achondroplasia: Member has a diagnosis of genetically confirmed achondroplasia AND epiphyses are confirmed open by diagnostic imaging AND Voxzogo (vosoritide) will be prescribed by or in consultation with a specialist with experience treating achondroplasia (e.g. endocrinologist).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VOYDEYA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member is using Voydeya (danicopan) as monotherapy. The member is using Voydeya (danicopan) as add-on therapy to a drug other than eculizumab or ravulizumab, e.g., PiaSky (crovalimab).
Required Medical Information	Paroxysmal Nocturnal Hemoglobinuria (PNH) (Initial): The member has been diagnosed with PNH by, or in collaboration with, a hematologist or PNH specialist AND The member is currently receiving eculizumab or ravulizumab, e.g., Soliris or Ultomiris AND Voydeya (danicopan) will be used as add-on therapy to eculizumab or ravulizumab AND The member is experiencing clinically significant extravascular hemolysis (EVH) as defined as both of the following: Hemoglobin (Hgb) less than or equal to 9.5 g/dL AND Absolute reticulocyte count greater than or equal to 120 x 10 ⁹ /L. Paroxysmal Nocturnal Hemoglobinuria (PNH) (Continuation): The member will continue using eculizumab or ravulizumab concomitantly with Voydeya (danicopan).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial and Continuation: Plan year duration
Other Criteria	
Part B Prerequisite	0

VOYXACT - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Primary immunoglobulin A nephropathy (IgAN): Member has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy AND Voyact is being used to slow kidney function decline in those at risk for disease progression AND One of the following applies to the member: member has tried and failed a maximally tolerated angiotensin-converting enzyme inhibitor (ACEi) or angiotensin II receptor blocker (ARB) OR member has a intolerance or contraindication to all angiotensin-converting enzyme inhibitors (ACEi) or angiotensin II receptor blockers. Members eGFR is greater than or equal to 30 mL/min/1.73m2 prior to starting Voyxact.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VPRIV - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 1 Gaucher Disease. The member must have a diagnosis of type 1 Gaucher's Disease AND the member has had prior therapy, contraindication, or intolerance to Elelyso (taliglucerase).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VRAYLAR - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Schizophrenia: The member must be utilizing Vraylar for the treatment of schizophrenia AND The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, or lurasidone. Bipolar I Disorder (manic or mixed episode): The member must be utilizing Vraylar for the treatment of bipolar I disorder (manic or mixed episode) AND The member must have documentation of prior therapy, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone, or aripiprazole. Bipolar 1 Disorder (Bipolar Depression): The member must have a diagnosis of bipolar 1 disorder (bipolar depression) and the member must have documentation of prior treatment, intolerance, or contraindication to quetiapine or lurasidone. Major Depressive Disorder: The member has a clinical diagnosis of major depressive disorder (MDD) as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D) AND The member has had previous treatment, contraindication, or intolerance to at least one antidepressant of adequate dose (i.e. as determined by the treating provider based on individual patient characteristics) and duration (i.e. at least 8 weeks) used as monotherapy for MDD AND The member must have documentation of prior therapy, intolerance, or contraindication to at least one generic oral atypical antipsychotic therapy that has been used as adjunctive (i.e. add-on) to antidepressant therapy AND Vraylar must be used as adjunctive treatment to antidepressant therapy and not as monotherapy.
Age Restriction	Schizophrenia: The member is 13 years of age or older. Bipolar I Disorder (manic or mixed episode): The member is 10 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VTAMA - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis: Diagnosis of chronic plaque psoriasis AND one of the following: BSA involvement greater than or equal to 3% and has had previous treatment, contraindication, or intolerance with a topical corticosteroid (e.g. triamcinolone 0.5% cream, betamethasone dipropionate) and a topical Vitamin D product (e.g. calcipotriene 0.005% cream) OR prescriber determines that psoriasis impacts a sensitive part of the body such that a topical corticosteroid would be inappropriate. Atopic Dermatitis: The member has a diagnosis of moderate to severe atopic dermatitis AND The member has at least 5% affected body surface area (BSA) AND The member has had previous treatment, intolerance, or contraindication to one of the following topical products: triamcinolone, mometasone, betamethasone, or clobetasol cream/ointment AND The member has had previous treatment, intolerance, or contraindication to a topical calcineurin inhibitor (e.g. tacrolimus). Previous treatment with a calcineurin inhibitor is not required for children less than 2 years of age.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VUMERITY - CAPSULE,DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYALEV - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Advanced Parkinsons Disease: The member must have a diagnosis of advanced Parkinsons disease AND The member is experiencing persistent motor fluctuations despite optimized carbidopa/levodopa therapy AND The member has tried or cannot use one of the following anti-Parkinson agents: Catechol-D-methyl transferase (COMT) inhibitor (e.g., entacapone), Monoamine oxidase B (MAO)-B inhibitor (e.g., rasagiline, selegiline), Dopamine agonists (e.g., pramipexole, ropinirole), or Amantadine. BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VYEPTI - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Migraine Prevention: Will be utilizing Vyepti (eptinezumab) for the preventative treatment of migraines AND has had previous treatment with Emgality AND Qulipta.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VYJUVEK - GEL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dystrophic Epidermolysis Bullosa (DEB): The member has a diagnosis of dystrophic epidermolysis bullosa (DEB) that has been confirmed via genetic testing that shows a mutation in the collagen type VII alpha 1 chain (COL7A1) AND Vyjuvek (beremagene geperpavec-svdt) is prescribed by a dermatologist or in consultation with a provider with experience in the management of DEB AND the member does not have current evidence or history of squamous cell carcinoma in the treatment area AND the member is concomitantly receiving supportive care for wounds AND documentation (e.g. chart notes, genetic testing results) must be submitted to support the requirements above.
Age Restriction	The member is 6 months of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VYKAT XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Hyperphagia: The member has a diagnosis of Prader-Willi syndrome (PWS) AND Provider attests that the diagnosis of Prader-Willi syndrome was confirmed by genetic testing with evidence of an abnormality in chromosome 15q11-q13 (e.g., chromosome deletion, maternal uniparental disomy, imprinting/translocation defects) AND The member has hyperphagia associated with Prader-Willi syndrome (e.g., lack of satiety, obsession with food, abnormal food seeking behavior).
Age Restriction	
Prescriber Restriction	Prescribed by or in consultation with a provider with expertise in the treatment of Prader-Willi syndrome (PWS).
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

VYLOY - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on Vyloy (zolbetuximab-clzb).
Required Medical Information	Gastric or Gastroesophageal Junction Adenocarcinoma (GEJ): The member has a diagnosis of locally advanced unresectable or metastatic, human epidermal growth factor receptor 2 (HER2)-negative, gastric or gastroesophageal junction (GEJ) adenocarcinoma AND The disease is claudin (CLDN) 18.2 positive as determined by an FDA approved test AND Vyloy (zolbetuximab-clzb) will be used in combination with a fluoropyrimidine- (fluorouracil [5-FU], capecitabine) and platinum-containing chemotherapy as first-line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	
Part B Prerequisite	0

VYNDAMAX - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): Member has a history of NYHA Class I through III Heart Failure AND Member has a diagnosis of ATTR-CM defined as: Significant cardiac involvement (e.g. substantial ventricular wall thickening or elevated intra-cardiac filling pressures) on echocardiography or cardiac MRI and one of the following: Medical records indicate presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) or Medical records indicate presence of amyloid deposits on analysis of biopsy specimens. The member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, Left Ventricular Assist Device (LVAD), Current Pregnancy.
Age Restriction	
Prescriber Restriction	The member is being treated by a specialist (e.g. cardiologist).
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYNDAQEL - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): Member has a history of NYHA Class I through III Heart Failure AND Member has a diagnosis of ATTR-CM defined as: Significant cardiac involvement (e.g. substantial ventricular wall thickening or elevated intra-cardiac filling pressures) on echocardiography or cardiac MRI and one of the following: Medical records indicate presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) or Medical records indicate presence of amyloid deposits on analysis of biopsy specimens. The member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, Left Ventricular Assist Device (LVAD), Current Pregnancy.
Age Restriction	
Prescriber Restriction	The member is being treated by a specialist (e.g. cardiologist).
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYTORIN 10-10 - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYTORIN 10-20 - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYTORIN 10-40 - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYTORIN 10-80 - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYVANSE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to Severe Binge Eating Disorder: The member has a diagnosis of Moderate to Severe Binge Eating Disorder (BED). ADD/ADHD: The member has a diagnosis of ADHD or ADD AND the member has had previous treatment with, contraindication, or intolerance to a long-acting stimulant (e.g. methylphenidate ER).
Age Restriction	Moderate to Severe Binge Eating Disorder (BED): 18 years of age or older. ADD/ADHD: 6 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYVGART - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Generalized Myasthenia Gravis (gMG): The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND The member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND The member has had previous treatment, contraindication, or intolerance to: Pyridostigmine AND at least 1 immunosuppressive therapy (e.g., azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide). Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) - Vyvgart Hytrulo only: The member has a diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) AND the member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of CIDP AND the member has had previous treatment with, or has a contraindication or intolerance to, an intravenous immune globulin (IVIG) or subcutaneous immune globulin (SCIG) product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYVGART HYTRULO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Generalized Myasthenia Gravis (gMG): The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND The member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND The member has had previous treatment, contraindication, or intolerance to: Pyridostigmine AND at least 1 immunosuppressive therapy (e.g., azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide). Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) - Vyvgart Hytrulo only: The member has a diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) AND the member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of CIDP AND the member has had previous treatment with, or has a contraindication or intolerance to, an intravenous immune globulin (IVIG) or subcutaneous immune globulin (SCIG) product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

VYXEOS - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression on Vyxeos (daunorubicin and cytarabine). Member has experienced disease progression on conventional daunorubicin and cytarabine regimen (e.g. "7+3")
Required Medical Information	Acute Myeloid Leukemia: The member has a diagnosis of therapy-related acute myeloid leukemia (t-AML) or AML with myelodysplasia-related changes (AML-MRC) AND one of the following applies: The member has newly diagnosed disease OR the member is using Vyxeos (daunorubicin and cytarabine) as post-remission therapy (if given in induction) OR the member is using Vyxeos (daunorubicin and cytarabine) as re-induction (if given in induction).
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	NA
Part B Prerequisite	0

WAINUA - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis. Member has documentation in the medical record of a mutation in the TTR gene AND Member currently experiences polyneuropathy and a comprehensive neurologic examination has ruled out other known causes of sensorimotor/autonomic neuropathy (e.g., chronic inflammatory demyelinating polyneuropathy) AND Member has a polyneuropathy disability score of IIIb or lower AND Member does not have history of a previous liver transplant.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

WAKIX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Narcolepsy. The member has a diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria AND The member has condition of excessive daytime sleepiness associated with narcolepsy as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND The member does not have risk factors for prolonged QT interval (e.g. drug interactions) AND The member has previous treatment, contraindication, or intolerance with: at least one CNS stimulant (e.g., methylphenidate, amphetamine salt combination immediate release) AND modafinil OR armodafinil. Cataplexy with narcolepsy: The member has condition of cataplexy associated with narcolepsy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	The member will be using no more than one of the following products at any given time: Lumryz (sodium oxybate), Xyrem (sodium oxybate), Xywav (calcium magnesium, potassium, and sodium oxybates), Sunosi (solriamfetol), or Wakix (pitolisant).
Part B Prerequisite	0

WAYRILZ - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Persistent or Chronic Immune Thrombocytopenia: Has a diagnosis of persistent or chronic immune thrombocytopenia (ITP), i.e., a disease duration of 3 months or more AND Is not using Wayrilz (rilzabrutinib) tablet as first-line therapy for the treatment of ITP AND Has had a prior trial, failure, or contraindication to a preferred eltrombopag product.
Age Restriction	
Prescriber Restriction	Prescribed by or in consultation with a hematologist or appropriate specialist.
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

WEGOVY - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	MASH with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults: Member has known or suspected relevant consumption of alcohol (greater than 20 grams per day for women or greater than 30 grams per day for men) or alcohol dependence.
Required Medical Information	Risk reduction of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease who are obese/overweight. The member is overweight OR has a diagnosis of obesity AND The member has established cardiovascular disease (e.g., previous myocardial infarction, previous stroke, or symptomatic peripheral artery disease) AND The member does not have a diagnosis of diabetes AND The member is optimized on standard of care medications to manage pre-existing cardiovascular disease (e.g., aspirin, antiplatelets, anticoagulants, angiotensin-converting enzyme inhibitors/angiotensin receptor blockers, beta-blockers) AND The member is using Wegovy in combination with a reduced calorie diet and increased physical activity. Metabolic dysfunction-associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults [Wegovy (semaglutide) injection formulation only]: The member has a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) [formerly known as nonalcoholic steatohepatitis (NASH)] confirmed by at least one of the following: Liver biopsy, Vibration-Controlled transient elastography (VCTE), or Magnetic resonance elastography (MRE). The member has moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) AND The member is using Wegovy in combination with a reduced calorie diet and increased physical activity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

WELIREG - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	von Hippel Lindau (VHL) Disease and Renal Cell Carcinoma (RCC): Member experiences disease progression on Welireg (belzutifan).
Required Medical Information	von Hippel Lindau VHL disease: The member has von Hippel Lindau (VHL) disease and the member does not require immediate surgery and The member requires treatment for: associated renal cell carcinoma (RCC) OR associated central nervous system hemangioblastomas OR pancreatic neuroendocrine tumors and Welireg (belzutifan) is administered as monotherapy. Renal Cell Carcinoma (RCC). The member has advanced renal cell carcinoma AND The member failed to achieve treatment goals or has documented intolerance when previously treated with both of the following: programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor AND a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) AND Welireg (belzutifan) is administered as monotherapy. Pheochromocytoma or Paraganglioma (PPGL): The member has locally advanced, unresectable, or metastatic pheochromocytoma or paraganglioma (PPGL).
Age Restriction	Pheochromocytoma or Paraganglioma (PPGL): The member is 12 years and older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

WELLBUTRIN SR - TABLET,SUSTAINED-RELEASE 12 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

WELLBUTRIN XL - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

WEZLANA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has had prior therapy, contraindication, or intolerance with Remicade or Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohns disease AND the member has had prior therapy, contraindication, or intolerance with Remicade OR Inflectra or infliximab AND a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek) or Tremfya.
Age Restriction	The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

WEZLANA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: Preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR the member has completed induction doses with an intravenous ustekinumab product. Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis AND the member has tried or cannot use at least two of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Psoriatic Arthritis: The member has a diagnosis of active psoriatic arthritis AND The member has had prior therapy, intolerance, or contraindication with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

WINLEVI - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acne: Member has a diagnosis of acne vulgaris AND Has had previous treatment, contraindication or intolerance with two of the following: generic tretinoin cream/gel (non-micro formulation), adapalene 0.1% gel, clindamycin lotion/solution/pledgets, erythromycin solution, clindamycin benzoyl peroxide 1%-5% gel.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

WINREVAIR - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization AND Member has WHO functional class II or IV symptoms AND One of the following: Member is stable on combination therapy (e.g. PDE5i (e.g. sildenafil or tadalafil) or Adempas (riociguat) and an ERA (e.g. ambrisentan, bosentan, macitentan) OR Member is stable on PAH monotherapy (e.g. PDE5i, sGC, ERA) due to intolerance of combination therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XADAGO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Parkinson's Disease Off Episodes: The member must have a diagnosis of Parkinson's disease AND The member must be experiencing off episodes while on levodopa/carbidopa therapy AND Xadago must be prescribed in combination with levodopa/carbidopa therapy AND The member must has tried or cannot use selegiline AND rasagiline.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XALATAN - DROPS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XALKORI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-small Cell Lung Cancer (NSCLC). The member has a diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC) and one of the following applies: The member has documented anaplastic lymphoma kinase (ALK)-positive NSCLC disease AND the member has a medical reason as to why Alecensa (alectinib) or Alunbrig (brigatinib) cannot be started or continued OR the member has disease which is ROS1 positive OR The member has a documented MET exon 14 skipping mutation. Anaplastic large cell lymphoma (ALCL): The member has a diagnosis of relapsed or refractory, systemic ALCL AND the disease has documented ALK-positivity AND Xalkori (crizotinib) is given as monotherapy. Inflammatory myofibroblastic tumor (IMT): the member has a diagnosis of unresectable, recurrent, or refractory IMT AND the disease has documented ALK-positivity AND Xalkori (crizotinib) is given as monotherapy.
Age Restriction	ALCL: The member is greater than 1 year of age up to young adult (21 years of age). IMT: The member is greater than 1 year of age and older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XANAX - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XANAX XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XATMEP - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with disease progression on Xatmep (methotrexate) (applies to acute lymphoblastic leukemia only).
Required Medical Information	Acute Lymphoblastic Leukemia (ALL): The member has a diagnosis of acute lymphoblastic leukemia AND The member will be using Xatmep (methotrexate) as part of a multi-phase, combination chemotherapy maintenance regimen AND The member has had previous treatment or intolerance to generic methotrexate. Polyarticular Juvenile Idiopathic Arthritis (pJIA): The member has a diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA) AND The member has had previous treatment or intolerance to generic methotrexate. BvsD Coverage Determination may also be required.
Age Restriction	The member is less than 18 years of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XCOPRI - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: The member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XCOPRI MAINTENANCE PACK - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: The member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XCOPRI TITRATION PACK - TABLET, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: The member has a diagnosis of partial-onset (focal) seizures AND Member has been unable to achieve seizure control with at least TWO other drugs for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, zonisamide, divalproex, gabapentin or topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XDEMVIY - DROPS

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Demodex blepharitis: Has a diagnosis of Demodex blepharitis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XELJANZ - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis (Xeljanz IR tablet and Xeljanz XR tablet only): Diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Psoriatic Arthritis (all formulations): The member has a diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya. Ulcerative Colitis (Xeljanz IR tablet and Xeljanz XR tablet only): the member has a diagnosis of moderately to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Polyarticular Juvenile Idiopathic Arthritis (Xeljanz IR and Oral solution only): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis AND has had prior therapy, contraindication or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Ankylosing Spondylitis (Xeljanz IR tablet and Xeljanz XR tablet only): The member must have a diagnosis of active ankylosing spondylitis AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx or Rinvoq.
Age Restriction	RA, Psoriatic Arthritis (Xeljanz XR), Ankylosing Spondylitis, and UC: 18 years of age or older. PJIA and Psoriatic Arthritis (Xeljanz IR and Oral solution only): 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	RA, Psoriatic Arthritis, PJIA, Ankylosing Spondylitis, Ulcerative Colitis: Plan Year Duration.
Other Criteria	

XELJANZ - TABLET

Part B Prerequisite	0

XELJANZ XR - TABLET, EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis (Xeljanz IR tablet and Xeljanz XR tablet only): Diagnosis of moderately to severely active rheumatoid arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Psoriatic Arthritis (all formulations): The member has a diagnosis of active psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq or Tremfya. Ulcerative Colitis (Xeljanz IR tablet and Xeljanz XR tablet only): the member has a diagnosis of moderately to severely active ulcerative colitis. The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Polyarticular Juvenile Idiopathic Arthritis (Xeljanz IR and Oral solution only): The member must have a diagnosis of active polyarticular juvenile idiopathic arthritis AND has had prior therapy, contraindication or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Ankylosing Spondylitis (Xeljanz IR tablet and Xeljanz XR tablet only): The member must have a diagnosis of active ankylosing spondylitis AND The member has had prior therapy, contraindication, or intolerance with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx or Rinvoq.
Age Restriction	RA, Psoriatic Arthritis (Xeljanz XR), Ankylosing Spondylitis, and UC: 18 years of age or older. PJIA and Psoriatic Arthritis (Xeljanz IR and Oral solution only): 2 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	RA, Psoriatic Arthritis, PJIA, Ankylosing Spondylitis, Ulcerative Colitis: Plan Year Duration.
Other Criteria	

XELJANZ XR - TABLET, EXTENDED RELEASE 24 HR

Part B Prerequisite	0

XEMBIFY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

XEMBIFY - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

XENAZINE - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of chorea associated with Huntington's disease. For Brand Xenazine: The member must have had previous treatment or intolerance with tetrabenazine.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XENPOZYME - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acid Sphingomyelinase Deficiency (ASMD): Member has a diagnosis of acid sphingomyelinase deficiency (ASMD) AND diagnosis of ASMD is confirmed by enzymatic assay OR genetic testing for mutations in the SMPD1 gene AND member has non-central nervous system manifestations of ASMD (e.g. splenomegaly, hepatomegaly, interstitial lung disease, thrombocytopenia) AND Xenpozyme (olipudase alfa) will be administered in a setting where appropriate medical support measures are available (e.g. CPR equipment).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XERMELO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Carcinoid Syndrome. The member has a diagnosis of carcinoid syndrome diarrhea inadequately controlled with somatostatin analog (SSA) therapy AND member has received 3 months of SSA therapy (i.e., octreotide acetate, Sandostatin LAR, or Somatuline Depot) at a stable dose AND Xermelo will be used concomitantly with SSA therapy. Reauthorization: Member has not experienced severe constipation or abdominal pain with Xermelo AND Xermelo continues to demonstrate clinical benefit, as evidenced by maintained reduction in the number of daily bowel movements from baseline AND Xermelo will continue to be used concomitantly with SSA therapy.
Age Restriction	The member must be 18 years or older.
Prescriber Restriction	Licensed Practitioner.
Coverage Duration	6 months duration.
Other Criteria	
Part B Prerequisite	0

XGEVA - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Concurrent use of bisphosphonate therapy (e.g., zoledronic acid, pamidronate).
Required Medical Information	Osteolytic Bone Metastases of Solid Tumors. The member has a diagnosis of solid tumor cancer (such as breast cancer, prostate cancer, or other solid tumor). The member must have documented bone metastases. The member has experienced disease progression, intolerance or contraindication following treatment with zoledronic acid (disease progression, intolerance or contraindication following treatment with zoledronic acid does not apply for prostate cancer or breast cancer). Multiple Myeloma: The member has a diagnosis of multiple myeloma AND the member has experienced disease progression, intolerance or contraindication following treatment with zoledronic acid. Giant Cell tumor of Bone: Diagnosis of giant cell tumor of bone. Hypercalcemia of malignancy: The member has hypercalcemia of malignancy, defined as an albumin-corrected calcium of greater than 12.5 mg/dL AND The member has had prior therapy, intolerance, or contraindication to intravenous bisphosphonate therapy (e.g. zoledronic acid). Applies only to beneficiaries enrolled in an MA-PD plan.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	1

XHANCE - AEROSOL, BREATH ACTIVATED (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP). The member must have a diagnosis of chronic rhinosinusitis with nasal polyps AND The member has had previous treatment, contraindication, or intolerance with two of the following intranasal products: fluticasone propionate, mometasone, Qnasl. Chronic Rhinosinusitis without Nasal Polyps (CRSsNP). The member must have a diagnosis of chronic rhinosinusitis without nasal polyps.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XIFAXAN - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Traveler's diarrhea: Member must have traveler's diarrhea caused by non-invasive strains of Escherichia Coli AND Member's condition is not complicated by fever or blood in the stool AND Member has tried or cannot use ciprofloxacin, levofloxacin, or azithromycin. Hepatic encephalopathy prophylaxis: Member has had at least one overt episode of hepatic encephalopathy (HE) AND Xifaxan (rifaximin) is being used to reduce the risk of HE recurrence. Irritable bowel syndrome with diarrhea (IBS-D): Member has a diagnosis of Irritable bowel syndrome with diarrhea (IBS-D).
Age Restriction	Must be age 12 or older for Travelers Diarrhea, Age 18 or older for Hepatic encephalopathy prophylaxis and IBS-D.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XIIDRA - DROPPERETTE, SINGLE-USE DROP DISPENSER

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Dry eye disease. Has a diagnosis of dry eye disease AND has had previous treatment, contraindication, or intolerance to the following: cyclosporine eye drops (generic Restasis), AND Eysuvis (loteprednol)*. *Previous treatment with Eysuvis (loteprednol) only applies if short-term treatment is an appropriate option.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XOLAIR - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Idiopathic Urticaria. Member has a diagnosis of chronic idiopathic urticaria. Member has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy, unless contraindicated. Member will continue to receive H1 antihistamine therapy while on Xolair, unless contraindicated. Moderate or Severe persistent asthma. The patient has a diagnosis of moderate or severe persistent asthma. The patient has evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. RAST) for a specific IgE or in vitro reactivity to a perennial aeroallergen. Member must have baseline serum IgE greater than or equal to 30 IU/ml. The patient has inadequately controlled asthma despite the use of Inhaled Corticosteroids.
Age Restriction	The patient is 12 years of age or older for diagnosis of chronic idiopathic urticaria. The patient is 6 years of age or older for moderate to severe persistent asthma. The patient is 18 years of age or older for nasal polyps. The patient is 1 year or older for IgE Mediated Food Allergy.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	Nasal Polyps: The member must meet all of the following criteria: have a diagnosis of nasal polyps (e.g., Chronic Rhinosinusitis with Nasal Polyposis [CRSwNP]) AND Xolair will be used in combination with a daily intranasal corticosteroid spray AND is unable to achieve adequate control of symptoms with maximum tolerated intranasal corticosteroid therapy. IgE Mediated Food Allergy: Member has been diagnosed with IgE mediated food allergy AND Member is using Xolair to reduce allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one of more foods AND Member is using in conjunction with food allergen avoidance.
Part B Prerequisite	0

XOLREMDI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	WHIM Syndrome (warts, hypogammaglobulinemia, infections, and myelokathexis) (Initial): The member has a diagnosis of WHIM syndrome confirmed by genotype variant of CXCR4 AND The member has a baseline ANC (absolute neutrophil count) less than or equal 400 cells/microliters AND Xolremdi is being prescribed by or in consultation with an immunologist, hematologist, geneticist, infectious disease specialist, or dermatologist. WHIM Syndrome (warts, hypogammaglobulinemia, infections, and myelokathexis) (Continuation): The member has had an increase in ANC from baseline OR has shown a decrease in frequency of infections from baseline.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Initial: 6 months. Continuation: Plan year duration.
Other Criteria	
Part B Prerequisite	0

XOSPATA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Myeloid Leukemia. The member has a diagnosis of acute myeloid leukemia AND The member has relapsed or refractory disease AND The member has documented FLT3 mutation positive disease AND The member will be using Xospata (gilteritinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XPOVIO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression on Xpovio (selinexor).
Required Medical Information	Multiple Myeloma: The member has a diagnosis of multiple myeloma AND The member has received at least one prior therapy AND The member will be using Xpovio in combination with dexamethasone and bortezomib (unless documented intolerance/contraindication to corticosteroid) OR The member has a diagnosis of multiple myeloma AND The member has received at least four prior therapies AND The member's disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents and an anti-CD38 monoclonal antibody AND The member will be using Xpovio (selinexor) in combination with dexamethasone (unless documented intolerance/contraindication to corticosteroid). Diffuse large B-cell lymphoma: The member has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma AND The member has received at least two prior lines of systemic therapy AND The member will be using Xpovio (selinexor) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XROMI - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Sickle Cell Anemia: Has a diagnosis of sickle cell anemia and is experiencing recurrent moderate to severe pain crises AND Has had previous treatment or intolerance with hydroxyurea capsule.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XTANDI - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Xtandi (enzalutamide).
Required Medical Information	Prostate Cancer (metastatic castration-resistant): The member has metastatic castration-resistant prostate cancer (CRPC). Prostate Cancer (non-metastatic castration-resistant): The member has a diagnosis of non-metastatic castration-resistant prostate cancer AND The member will use Xtandi (enzalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]). Prostate Cancer (metastatic castration-sensitive): the member has a diagnosis of metastatic castration-sensitive prostate cancer AND the member will use Xtandi (enzalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]). Prostate Cancer (non-metastatic castration-sensitive): The member has a diagnosis of non-metastatic castration-sensitive prostate cancer (nmCSPC) with biochemical recurrence at high risk for metastasis (biochemical recurrence at high risk for metastasis defined as prostate-specific antigen [PSA] doubling time less than or equal to 9 months, PSA greater than or equal to 1 ng/mL post radical prostatectomy, or screening PSA greater than or equal to 2 ng/mL above nadir post radiotherapy).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XULTOPHY 100/3.6 - INSULIN PEN (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus. Member has a diagnosis of type 2 diabetes mellitus AND Member is using as adjunctive therapy to diet and exercise to improve glycemic control AND Member is not using in combination with any other product containing liraglutide or another GLP-1 receptor agonist AND Member is not using in combination with prandial insulin AND Member has had previous treatment with Soliqua (insulin glargine/lixisenatide).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

XYOSTED - AUTO-INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member has one of the following diagnoses: Primary hypogonadism: testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals OR Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. AND Member has had one of the following: Documentation of two morning serum testosterone levels (total or free) that are less than the reference range for the lab, taken at separate times, prior to treatment OR Documentation of a serum testosterone level (total or free) that is less than or within the reference range for the lab, when already on treatment. Member has had previous treatment with a generic testosterone 1.62% gel AND one of the following: testosterone cypionate intramuscular oil or testosterone enanthate intramuscular oil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

XYREM - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Narcolepsy with Cataplexy: The member has a diagnosis of narcolepsy with cataplexy AND for Brand Xyrem requests, previous treatment with sodium oxybate (generic Xyrem). Narcolepsy with excessive daytime sleepiness: The member has a diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria AND the member has condition of excessive daytime sleepiness (EDS) associated with narcolepsy as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND previous treatment, intolerance, or contraindication to at least one CNS stimulant (e.g. methylphenidate, amphetamine salt combination immediate release) or modafinil or armodafinil AND for Brand Xyrem requests, previous treatment with sodium oxybate (generic Xyrem).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	The member will be using no more than one of the following products at any given time: Xyrem (sodium oxybate), Xywav (calcium magnesium, potassium, and sodium oxybates), Lumryz (sodium oxybate), Wakix (pitolisant), or Sunosi (solriamfetol).
Part B Prerequisite	0

XYWAV - SOLUTION, ORAL

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Narcolepsy with cataplexy: The member must have a diagnosis of narcolepsy with cataplexy AND Previous treatment with sodium oxybate (generic Xyrem). Narcolepsy with excessive daytime sleepiness: The member has a diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria AND The member has condition of excessive daytime sleepiness (EDS) associated with narcolepsy as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND Previous treatment, contraindication, or intolerance with: at least one CNS stimulant (e.g., methylphenidate or amphetamine salt combination immediate release) OR modafinil OR armodafinil AND Previous treatment with sodium oxybate (generic Xyrem). Idiopathic Hypersomnia (IH): The member has a diagnosis of idiopathic hypersomnia (IH) according to ICSD-3 or DSM-5 criteria AND the member has symptoms of idiopathic hypersomnia (IH) as confirmed by documented sleep testing (e.g. polysomnography, multiple sleep latency test) AND Previous treatment, contraindication, or intolerance with: at least one CNS stimulant (e.g., methylphenidate or amphetamine salt combination immediate release) OR modafinil OR armodafinil.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	The member will be using no more than one of the following products at any given time: Xywav (calcium magnesium, potassium, and sodium oxybates), Xyrem (sodium oxybate), Lumryz (sodium oxybate), Wakix (pitolisant), or Sunosi (solriamfetol).
Part B Prerequisite	0

yargesa - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 1 Gaucher Disease. The member must have a diagnosis of type 1 Gaucher's Disease AND the member has had prior therapy, contraindication, or intolerance to Elelyso (taliglucerase).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

YCANTH - SOLUTION WITH APPLICATOR (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Molluscum contagiosum: The member has a diagnosis of molluscum contagiosum AND The member has had previous treatment, contraindication, or intolerance with a conventional therapy (e.g. podofilox, cimetidine, imiquimod).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

YERVOY - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Melanoma: Concomitant Zelboraf (vemurafenib), Tafinlar (dabrafenib), Cotellic (cobimetnib) or Mekinist (trametinib) therapy AND The member has had progression of disease on adjuvant therapy with Yervoy (ipilimumab). MSI-H or dMMR: Disease progression while on or following previous anti-CTLA4-based combinations (e.g., Opdivo [nivolumab] with Yervoy [ipilimumab]). Hepatocellular carcinoma: Disease progression while on or following previous anti-CTLA4-based combinations (e.g., Imjudo [tremelimumab-actl] with Imfinzi [durvalumab]).
Required Medical Information	Melanoma. The member has a diagnosis of unresectable or metastatic melanoma OR Adjuvant treatment of cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 millimeter who have undergone complete resection, including total lymphadenectomy. The member is naive to Yervoy (ipilimumab). The member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2. Melanoma - Reauthorization Criteria unresectable or metastatic. The member had stable disease, partial response or complete response for greater than 3 months following the completion of initial induction (completion of four cycles within a 16 week period. Members who were unable to tolerate or receive the complete induction regimen within 16 weeks of initiation will not receive approval). AND The member has progressive disease, necessitating reinduction therapy with Yervoy (ipilimumab). AND The member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2. Reauth adjuvant treatment of cutaneous melanoma. The member has not had disease recurrence or unacceptable toxicity with Yervoy (ipilimumab) AND The total duration of treatment is less than 3 years AND The member has an ECOG performance status of 0-2. Renal Cell Carcinoma. The member has a diagnosis of advanced renal cell carcinoma (RCC) AND The member has predominant clear cell histology AND The member will be using Yervoy (ipilimumab) in combination with Opdivo (nivolumab) AND The member will be using for first line therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	4 Months Duration

YERVOY - VIAL (ML)

Other Criteria	Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) Metastatic Colorectal Cancer. The member has a diagnosis of unresectable or metastatic colorectal cancer with documented microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) AND The member will be using Yervoy (ipilimumab) in combination with Opdivo (nivolumab). Hepatocellular carcinoma: The member has a diagnosis of hepatocellular carcinoma AND The member will be using Yervoy (ipilimumab) in combination with Opdivo (nivolumab). Non-small cell lung cancer (NSCLC) -- First Line Therapy: The member must have a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND one of the following applies: Disease with PD-L1 expression greater than or equal to 1% with no EGFR or ALK genomic tumor aberrations and given as first line therapy AND Tumor expresses PD-L1 as determined by an FDA-approved test AND Will be used in combination with Opdivo (nivolumab) OR Disease with no EGFR or ALK genomic tumor aberrations and given as first line therapy AND Will be used in combination with Opdivo (nivolumab) AND Will be used in combination with two cycles of platinum doublet chemotherapy. Malignant pleural mesothelioma: The member has a diagnosis of unresectable malignant pleural mesothelioma AND The member will be using for first-line or subsequent treatment, if not administered first-line AND Yervoy (ipilimumab) will be used in combination with Opdivo (nivolumab). Esophageal Cancer (squamous cell carcinoma): the member has unresectable advanced, recurrent, or metastatic squamous cell carcinoma of the esophagus AND Yervoy will be given as first line treatment in combination with Opdivo.
Part B Prerequisite	0

YESINTEK - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe chronic plaque psoriasis (SC formulation only): The member must have a diagnosis of moderate to severe chronic plaque psoriasis AND The member has had prior therapy or intolerance to one or more oral systemic treatments (e.g. methotrexate, cyclosporine) or contraindication to all conventional oral systemic treatments. Psoriatic arthritis (SC formulation only): The member must have a diagnosis of active psoriatic arthritis. Moderately to severely active Crohn's disease (IV and SC formulations). The member must have a diagnosis of moderately to severely active Crohn's disease. Moderate to severely active ulcerative colitis (IV and SC formulations): The member must have a diagnosis of moderately to severely active ulcerative colitis.
Age Restriction	Moderate to severe chronic plaque psoriasis and psoriatic arthritis: The member must be 6 years of age or older. For Crohn's Disease and Ulcerative Colitis: The member must be 18 years of age or older.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

YIMMUGO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	For Medicare Part D requests, Humana's preferred product is Gamunex-C. Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome, X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/L),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/mcL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/mcL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogeneic hematopoietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm³, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restriction	Member is younger than 13 years of age for treatment of AIDS/HIV.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

YIMMUGO - VIAL (ML)

Other Criteria	Infections in Low-Birthweight Neonates. Prophylaxis and treatment of infections in high-risk preterm low-birth weight members. Diagnosed staphylococcal/streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, undrainable focus is present or has persistent oliguria with pulmonary edema. Diagnosed autoimmune neutropenia and G-CSF therapy not appropriate. Autoimmune Hemolytic Anemia. Refractory to corticosteroid therapy and splenectomy, or those whom corticosteroid therapy and splenectomy is contraindicated. Myasthenia Gravis. Experiencing acute myasthenic crisis with decompensation. Has tried or cannot use at least 1 other treatment (e.g., corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Guillain-Barre Syndrome. Severely affected by the disease and requires aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed relapsing-remitting multiple sclerosis and has tried or cannot use at least one conventional therapy (Betaseron, Avonex, etc). Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. 1 of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs OR Muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambert-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has tried or cannot use at least 1 of the following: diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections OR member is experiencing hypogammaglobulinemia (IgG less than or equal to 400mg/dL). Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisita, etc. Has tried or cannot use at least 1 conventional therapy or has rapidly progressive disease in which clinical response could not be affected quickly enough using conventional agents. Stiff-Person Syndrome. Has tried or cannot use at least 1 other intervention (e.g. diazepam). Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or members with hemolytic anemia/thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy, extensive burns, or collagen-vascular disease. BvsD Coverage Determination may also be required.
Part B Prerequisite	0

YONDELIS - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Yondelis (trabectedin)
Required Medical Information	Liposarcoma/Leiomyosarcoma: The member has unresectable or metastatic liposarcoma or leiomyosarcoma AND The member has received prior anthracycline (e.g., doxorubicin) containing regimen. Soft Tissue Sarcoma. Yondelis (trabectedin) will be used as monotherapy for palliative treatment and one of the following applies: The member has a diagnosis of unresectable or progressive retroperitoneal or intraabdominal soft tissue sarcoma OR the member has a diagnosis of angiosarcoma or rhabdomyosarcoma OR the member has a diagnosis stage IV soft tissue sarcoma of the extremity/superficial trunk, head/neck, or recurrent disease with disseminated metastases.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

YONSA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on Yonsa (abiraterone acetate).
Required Medical Information	Prostate Cancer (mCRPC). The member has a diagnosis of metastatic castration-resistant prostate cancer (CRPC) AND The member will be using Yonsa (abiraterone acetate) in combination with methylprednisolone AND The member has an intolerance to or has had prior therapy with generic abiraterone acetate.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

YORVIPATH - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member is utilizing for acute post-surgical hypoparathyroidism.
Required Medical Information	Chronic Hypoparathyroidism: Diagnosis of chronic hypoparathyroidism of postsurgical, autoimmune, genetic, or idiopathic etiology based on hypocalcemia in the setting of inappropriately low serum PTH levels AND Member is currently receiving conventional therapy (e.g., active vitamin D (calcitriol), elemental calcium) and hypoparathyroidism is not adequately controlled AND Member's recent serum 25-hydroxyvitamin D is in normal range and albumin-adjusted serum calcium is greater than or equal to 7.8 mg/dL AND Yorvipath is prescribed by or in consultation with an endocrinologist.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

YUFLYMA(CF) - SYRINGE KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

YUFLYMA(CF) - SYRINGE KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

YUFLYMA(CF) AI CROHN'S-UC-HS - AUTO-INJECTOR, KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

YUFLYMA(CF) AI CROHN'S-UC-HS - AUTO-INJECTOR, KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

YUFLYMA(CF) AUTOINJECTOR - AUTO-INJECTOR, KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

YUFLYMA(CF) AUTOINJECTOR - AUTO-INJECTOR, KIT (EA)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

YUPELRI - VIAL, NEBULIZER (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema. The member has had previous treatment, contraindication, or intolerance to Spiriva (i.e. Spiriva Handihaler, Spiriva Respimat). For Yupelri requests: BvsD Coverage Determination may also be required.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

YUSIMRY(CF) PEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Diagnosis of active ankylosing spondylitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Cosentyx, or Rinvoq. Psoriatic Arthritis: Diagnosis of active psoriatic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, Rinvoq, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya. Rheumatoid Arthritis: Diagnosis of moderately to severely active rheumatoid arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, or Rinvoq. Moderate to severe Chronic Plaque Psoriasis: Diagnosis of moderate to severe chronic plaque psoriasis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Enbrel, Skyrizi, Cosentyx, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), or Tremfya.
Age Restriction	Must be 18 years of age for Rheumatoid Arthritis, Moderate to severe Chronic Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Oral Ulcers Associated with Behcets Disease. Must be two years of age or older for moderately to severely active polyarticular juvenile idiopathic arthritis and Uveitis. Must be 6 years or older for Crohns Disease. Must be 5 years of age or older for Ulcerative Colitis. Must be 12 years of age or older for Hidradenitis Suppurativa.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

YUSIMRY(CF) PEN - PEN INJECTOR (ML)

Other Criteria	Oral Ulcers Associated with Behcets Disease: Diagnosis of Behcets disease AND member will be using for the treatment of oral ulcers AND has had previous treatment with, contraindication, or intolerance to a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz]. Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya. Crohn's Disease: The member has a diagnosis of Crohn's disease. Member must have failed to achieve symptom control after previous treatment with two of the following: preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], Skyrizi, a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Rinvoq, or Tremfya. Hidradenitis Suppurativa: The member must have a diagnosis of moderate to severe Hidradenitis Suppurativa. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz] and Cosentyx SQ. Uveitis: The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis. Member must have failed to achieve symptom control after previous treatment with preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz].
Part B Prerequisite	0

YUTREPIA - CAPSULE, WITH INHALATION DEVICE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH): Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization AND Prior therapy, intolerance or contraindication to an endothelin receptor antagonist (e.g. bosentan, ambrisentan, macitentan) AND a phosphodiesterase type 5 inhibitor (e.g. sildenafil, tadalafil) AND The member must have had prior therapy, intolerance, or contraindication to Tyvaso DPI (treprostinil) or Uptravi (selexipag) AND Will continue one of the following in combination with Yutrepria (treprostinil): endothelin receptor antagonist treatment (e.g., bosentan, ambrisentan, macitentan) OR phosphodiesterase type 5 inhibitor (e.g. sildenafil, tadalafil). Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD): Diagnosis of Pulmonary Hypertension associated with Interstitial Lung Disease (WHO Group 3) confirmed by both: Right heart catheterization with evidence of pulmonary hypertension AND High Resolution Computer Tomography (HRCT) or Lung Biopsy with evidence of Interstitial Lung Disease AND The member must have had prior therapy, intolerance, or contraindication to Tyvaso DPI (treprostinil).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

YUVIWEL - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	Pending CMS Review
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restriction	Pending CMS Review
Prescriber Restriction	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Part B Prerequisite	Pending CMS Review

ZALTRAP - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on Zaltrap.
Required Medical Information	Metastatic Colorectal Cancer: The member has a diagnosis of metastatic colorectal cancer AND The member is using Zaltrap in combination with irinotecan or FOLFIRI (leucovorin, irinotecan, 5-fluorouracil) chemotherapy AND At least one of the following applies: Zaltrap is being used as second line therapy AND The member experienced disease progression or resistance with an Oxaliplatin containing regimen OR The member has unresectable metachronous metastases and has received previous adjuvant FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX(capecitabine and oxaliplatin)
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZARXIO - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Neutropenia in Myelodysplastic Syndromes: The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia: The member must have a diagnosis of febrile neutropenia AND filgrastim product must be used in adjunct with appropriate antibiotics in high risk members. Febrile Neutropenia Prophylaxis: The member must have a diagnosis of non-myeloid malignancy (e.g., solid tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimens risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 Months Duration

ZARXIO - SYRINGE (ML)

Other Criteria	Febrile Neutropenia Prophylaxis, in members with acute myeloid leukemia receiving chemotherapy: The member must have a diagnosis Acute Myeloid Leukemia (AML). The member must be receiving either induction chemotherapy OR consolidation Chemotherapy AND The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy. Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following Hematopoietic Stem Cell Transplant (HCST): The member must have had a Hematopoietic Stem Cell Transplant (HCST) (e.g. bone marrow transplant, peripheral-blood progenitor cell (PBPC) transplant) for a non-myeloid malignancy AND The member is not administering filgrastim product earlier than 24 hours after cytotoxic chemotherapy or within 24 hours before chemotherapy Harvesting of peripheral blood stem cells: The member is using as a component of a hematopoietic stem cell mobilization protocol and one of the following applies: is scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, is storing cells for a possible future autologous transplant, or is donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic disorder, chronic (Severe), Symptomatic: The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia. Neutropenia in AIDS patients: The member must have a diagnosis of AIDS with neutropenia. Treatment of Aplastic Anemia: The member must have a diagnosis of Aplastic Anemia. Treatment of Agranulocytosis: The member must have a diagnosis of congenital or drug induced agranulocytosis. Hematopoietic Syndrome of Acute radiation syndrome: The member has been acutely exposed to myelosuppressive doses of radiation.
Part B Prerequisite	0

ZAVESCA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 1 Gaucher Disease. The member must have a diagnosis of type 1 Gaucher's Disease AND the member has had prior therapy, contraindication, or intolerance to Elelyso (taliglucerase).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZAVZPRET - SPRAY, NON-AEROSOL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Acute Migraines: Will be utilizing Zavzpret (zavegepant) nasal spray for the acute treatment of migraines AND Has had previous treatment, intolerance, or contraindication to sumatriptan nasal spray and Has had previous treatment, intolerance, or contraindication to Ubrelvy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZEGERID - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZEJULA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].
Required Medical Information	Epithelial Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer subsequent line maintenance therapy: The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Zejula (niraparib) as a monotherapy* AND *Discontinue Bevacizumab product before initiating maintenance therapy with Zejula. Advanced Ovarian Cancer, Fallopian Tube, or Peritoneal Cancer First Line Maintenance Therapy: member has a diagnosis of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer AND Members disease is associated with homologous recombination deficiency (HRD) positive status defined by either: a deleterious OR suspected deleterious BRCA mutation or genomic instability, as defined by an FDA approved test. Member is in complete response or partial response to first line treatment with platinum based chemotherapy AND member will utilize Zejula (niraparib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZELBORAF - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Tafinlar (dabrafenib), Mekinist (trametinib), Braftovi (encorafenib), or Mektovi (binimetinib). Members that have experienced disease progression while on Zelboraf (vemurafenib). Members that have experienced disease progression while on prior anti-BRAF/MEK combination therapy [e.g. Braftovi (encorafenib) with Mektovi (binimetinib) or Tafinlar (dabrafenib) with Mekinst (trametinib)].
Required Medical Information	Melanoma: The member has a diagnosis of Unresectable or Stage IV Metastatic melanoma. The member has a documented BRAF V600 activating mutation. The member will be using Zelboraf (vemurafenib) as monotherapy OR in combination with Cotellic (cobimetinib). Erdheim-Chester Disease: The member has a diagnosis of Erdheim-Chester Disease AND The member has a documented BRAF V600 mutation AND The member will be using Zelboraf (vemurafenib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZELSUVMI - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Molluscum contagiosum: The member has a diagnosis of molluscum contagiosum AND The member has had previous treatment, contraindication, or intolerance with a conventional therapy (e.g. podofilox, cimetidine, imiquimod).
Age Restriction	
Prescriber Restriction	
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

zelvysia - POWDER IN PACKET (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Phenylketonuria (PKU): The member has a diagnosis of PKU AND for brand requests the member has had previous treatment, contraindication, or intolerance to generic sapropterin.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZEMAIRA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	IgA deficient members or presence of antibodies against IgA.
Required Medical Information	The member must meet ALL of the following criteria: Diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed AND Has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or PI (null, null) or phenotypes associated with reduced serum alpha-1 antitrypsin concentrations, AND an initial serum alpha 1-antitrypsin concentration of less than 57mg/dL when measured by nephelometry OR less than 80 mg/dL when measured by radial immunodiffusion. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema.)
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZEPATIER - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members with moderate to severe hepatic impairment (Child Pugh B or C).
Required Medical Information	Chronic Hepatitis C: The member must have a diagnosis of chronic hepatitis C (HCV) infection. The member must have documented genotype (GT) 1 or 4 infection. Member must have failed to achieve SVR after completing a full course of or has a contraindication to Epclusa. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	12 to 16 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.
Other Criteria	
Part B Prerequisite	0

ZEPBOUND - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member does NOT have a diagnosis of diabetes (type 1 or type 2).
Required Medical Information	Obstructive Sleep Apnea (OSA): Member has a diagnosis of moderate to severe obstructive sleep apnea (OSA) AND Member is obese (BMI greater than or equal to 30 kg/m2) AND Member has apnea hypopnea index (AHI) baseline greater than or equal to 15 on polysomnogram (PSG) or member has respiratory event index (REI) greater than or equal to 15 based on home sleep apnea test (HSAT) AND Provider attests to member using Zepbound in combination with ongoing lifestyle modifications for weight loss.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZEPBOUND KWIKPEN - PEN INJECTOR (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member does NOT have a diagnosis of diabetes (type 1 or type 2).
Required Medical Information	Obstructive Sleep Apnea (OSA): Member has a diagnosis of moderate to severe obstructive sleep apnea (OSA) AND Member is obese (BMI greater than or equal to 30 kg/m2) AND Member has apnea hypopnea index (AHI) baseline greater than or equal to 15 on polysomnogram (PSG) or member has respiratory event index (REI) greater than or equal to 15 based on home sleep apnea test (HSAT) AND Provider attests to member using Zepbound in combination with ongoing lifestyle modifications for weight loss.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZEPOSIA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis: The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide. Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has tried or cannot use two of the following: a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZEPOSIA STARTER KIT (28-DAY) - CAPSULE, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis: The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide. Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has tried or cannot use two of the following: a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZEPOSIA STARTER PACK (7-DAY) - CAPSULE, DOSE PACK

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis: The member has a diagnosis of a relapsing form of multiple sclerosis, to include relapsing-remitting or active secondary progressive disease, OR the member has a diagnosis of clinically isolated syndrome (CIS) AND The member has tried or cannot use at least two of the following products: dimethyl fumarate, fingolimod, a glatiramer product (Glatopa, or generic glatiramer), Kesimpta (ofatumumab), or teriflunomide. Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND the member has tried or cannot use two of the following: a preferred adalimumab product [i.e., Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZEPZELCA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member experiences disease progression on Zepzelca (lurbinectedin).
Required Medical Information	Small cell lung cancer (Single agent): The member has a diagnosis of metastatic small cell lung cancer AND The member had progression on or after treatment with platinum-based chemotherapy AND Zepzelca (lurbinectedin) will be used as a single agent. Small cell lung cancer (Combination therapy): The member has a diagnosis of extensive stage small cell lung cancer (ES-SCLC) AND The member has not experienced disease progression after first-line induction therapy with the following regimen: an atezolizumab product (Tecentriq, Tecentriq Hybreza) in combination with carboplatin and etoposide AND Zepzelca (lurbinectedin) will be used in combination with an atezolizumab product (Tecentriq, Tecentriq Hybreza) as maintenance therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZESTRIL - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZETIA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZEVALIN (Y-90) - KIT

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Members that have received previous radioimmunotherapy with Zevalin (ibritumomab tiuxetan).
Required Medical Information	The member has relapsed or refractory, low-grade or follicular B-cell non-Hodgkin's lymphoma (NHL) OR The member has previously untreated (radioimmunotherapy) follicular NHL and achieved a partial or complete response to first-line chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	1 month Duration
Other Criteria	
Part B Prerequisite	0

ZIANA - GEL (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZIEXTENZO - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Same day administration of requested product with myelosuppressive chemotherapy or therapeutic radiation. (NOTE: This exclusion is not applicable to products worn on the body and applied the same day as myelosuppressive chemotherapy.) Requested product will be administered more frequently than once every two weeks or more than once per chemotherapy cycle.
Required Medical Information	Febrile Neutropenia Prophylaxis: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND The member must have a diagnosis of non-myeloid malignancy (e.g. Solid Tumors) AND The member must also meet ONE OR MORE of the following criteria (NOTE: the chemotherapy regimen's risk of febrile neutropenia should be assessed per current ASCO and NCCN guidelines for myeloid growth factors): Current chemotherapy regimen has a risk of febrile neutropenia of greater than 20% OR Current chemotherapy regimen has a risk of febrile neutropenia of 10 to 20%, and member has at least ONE of the following risk factors OR Current chemotherapy regimen has a risk of febrile neutropenia of less than 10% and member has at least TWO of the following risk factors: Risk Factors: Prior chemotherapy or radiation therapy, Persistent neutropenia, Bone marrow involvement by tumor, Recent surgery and/or open wounds, Liver dysfunction (bilirubin greater than 2 mg/dL), Renal dysfunction (creatinine clearance less than 50 mL/min), Age greater than 65 receiving full chemotherapy dose intensity, OR Member experienced previous neutropenic fever complication or dosing limiting neutropenic event on a prior cycle of similar chemotherapy OR The member is receiving a dose-dense chemotherapy regimen OR Member is using as secondary prophylaxis in the curative setting to maintain dosing schedule and/or intensity.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	6 months duration
Other Criteria	Hematopoietic Subsyndrome of Acute Radiation Syndrome: The member has been acutely exposed to myelosuppressive doses of nontherapeutic radiation. Stem Cell Mobilization for Autologous Donors: The member had previous treatment with or intolerance to a Udenyca (pegfilgrastim-cbqv) product AND Requested product is being used in combination with plerixafor as part of a hematopoietic stem cell mobilization regimen.

ZIEXTENZO - SYRINGE (ML)

Part B Prerequisite	0

ZIIHERA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Member has experienced disease progression Ziihera (zanidatamab-hrii).
Required Medical Information	Biliary Tract Cancer (BTC): The member has a diagnosis of unresectable or metastatic biliary tract cancer (BTC) AND The disease is documented as human epidermal growth factor receptor 2 (HER2)-positive [IHC 3+], as determined by an FDA approved test AND The member has previously been treated with at least one prior line of therapy (i.e., gemcitabine-based regimen) AND Ziihera (zanidatamab-hrii) will be given as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZILBRYSQ - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Generalized Myasthenia Gravis (gMG): The member has a diagnosis of generalized myasthenia gravis AND The presence of anti-acetylcholine receptor (AChR) antibodies has been confirmed AND The member is being treated by, or under the supervision of, a specialist (e.g. neurologist) experienced in the management of generalized myasthenia gravis AND The member has tried or cannot use Vyvgart OR Vyvgart Hytrulo.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZILRETTA - SUSPENSION,EXTENDED RELEASE VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Osteoarthritis of the knee: The member has documented symptomatic osteoarthritis of the knee and therapy is limited to the knee AND Has not previously been treated with Zilretta in the same knee. (Per FDA label: efficacy and safety of repeat administration have not been demonstrated) AND Has had an inadequate response to previous treatment with TWO different short-acting intra-articular steroids (e.g. triamcinolone AND methylprednisolone or betamethasone AND dexamethasone, etc.).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZILXI - FOAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Rosacea: Member must be using to treat inflammatory lesions of rosacea AND must have had previous treatment, intolerance, or contraindication with topical metronidazole AND must have had previous treatment, intolerance, or contraindication with nondelayed release oral doxycycline (e.g. doxycycline monohydrate 50 mg capsule/tablet or 100 mg capsule/tablet or doxycycline hyclate 20 mg tablet or 100 mg capsule/tablet).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZIMHI - SYRINGE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Opioid overdose: is using the requested product for emergency treatment of known or suspected opioid overdose AND has had a trial within the past 12 months with one of the following: generic naloxone injection, generic naloxone nasal spray, or Kloxxado nasal spray.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZIRABEV - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Malignant Pleural Mesothelioma, Soft Tissue Sarcoma, Recurrent Primary CNS Tumor (including Glioblastoma multiforme), Renal Cell Carcinoma, Non-small cell lung cancer (non-squamous cell histology): The member has experienced disease progression while on or following a bevacizumab product. Metastatic colorectal cancer: A bevacizumab product may not be used in conjunction with Vectibix (panitumumab) or Erbitux (cetuximab).
Required Medical Information	For Avastin (bevacizumab), Alymsys (bevacizumab-maly), Jobevne (bevacizumab-nwgd), and Vegzelma (bevacizumab-adcd) oncology requests: member must have an intolerance or contraindication with Mvasi or Zirabev. Metastatic colorectal cancer: metastatic colorectal cancer AND 1 of the following applies: using a bevacizumab product in combo with fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemo for 1st or 2nd-line therapy OR in combo with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemo for 2nd-line therapy in patients who have progressed on 1st-line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). NSCLC with non-squamous cell histology AND the disease is unresectable, locally advanced, recurrent, or metastatic AND A bevacizumab product will be used as part of a supported combination chemotherapy. Hepatocellular carcinoma: unresectable or metastatic HCC AND a bevacizumab product will be used as 1st line therapy in combo with an atezolizumab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ZIRABEV - VIAL (ML)

Other Criteria	Renal cell carcinoma: Member has RCC and a bevacizumab product will be used in combo with interferon alpha. Recurrent Primary CNS Tumor (including Glioblastoma multiforme): Diagnosis of progressive or recurrent glioblastoma or anaplastic glioma AND a bevacizumab product is being used as a single agent or in combo with irinotecan, carmustine, lomustine or temozolomide AND the member does not have a CNS hemorrhage. Soft Tissue Sarcoma: One of the following applies: Diagnosis of angiosarcoma AND a bevacizumab product is being used as a single agent OR The member has a diagnosis of solitary fibrous tumor and a bevacizumab product is being used in combo with temozolomide. Macular Retinal Edema. Avastin is being used to treat central or branch retinal vein occlusion with macular retinal edema. Cervical Cancer: member has recurrent, or metastatic cervical cancer AND A bevacizumab product will be used as part of a supported combination therapy. Endometrial Cancer: The member has a diagnosis of endometrial cancer AND One of the following applies: The member has stage III-IV disease or recurrent disease AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, followed by maintenance with a bevacizumab product maintenance OR The member has recurrent disease AND a bevacizumab product monotherapy will be used as second-line or subsequent therapy if not previously used. Malignant Pleural Mesothelioma. Diagnosis of unresectable malignant pleural mesothelioma and a bevacizumab product will be used in combo with cisplatin and pemetrexed or carboplatin and pemetrexed followed by maintenance with a bevacizumab product (for responders). Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of epithelial ovarian, fallopian tube or primary peritoneal cancer AND One of the following applies: The disease is recurrent, platinum-resistant AND a bevacizumab product will be used in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan AND the member has not received more than 2 prior chemotherapy regimens OR The disease is recurrent, platinum-sensitive AND a bevacizumab product will be used in combination with carboplatin and paclitaxel, or in combination with carboplatin and gemcitabine, followed by a bevacizumab product monotherapy AND The disease is stage III or IV AND initial surgical resection was completed AND a bevacizumab product will be used in combo with carboplatin and paclitaxel, followed by a bevacizumab product monotherapy OR . Age Related Macular Degeneration (Avastin requests only): Avastin (bevacizumab) is being used to treat age related macular degeneration. Diabetic Macular Edema (Avastin requests only): Avastin (bevacizumab) is being used to treat diabetic macular edema.
Part B Prerequisite	0

ZITUVIMET - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZITUVIMET XR - TABLET,EXTENDED RELEASE MULTIPHASE 24 HR

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZITUVIO - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Type 2 Diabetes Mellitus: Member has a diagnosis of Type 2 Diabetes Mellitus and has had previous treatment with, contraindication, or intolerance to Januvia or Janumet or Janumet XR AND Tradjenta or Jentadueto or Jentadueto XR.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZOCOR - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZOKINVY - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	NA
Required Medical Information	Progeroid Laminopathies: Member must meet ALL of the following criteria: Diagnosis of one of the following: Hutchinson-Gilford Progeria syndrome OR Progeroid Laminopathies with either Heterozygous LMNA mutation with progerin-like protein accumulation OR Homozygous or Compound Heterozygous ZMPTSTE24 mutations. AND Body Surface Area of 0.39 meters squared or greater.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	NA
Part B Prerequisite	0

ZOLADEX - IMPLANT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	All Indications: Concomitant use with other LHRH agents. Breast Cancer Only: Zoladex should not be continued or restarted after malignant disease progression. Breast Cancer, Endometriosis, Endometrial Thinning Only: Abnormal vaginal bleeding of unknown etiology.
Required Medical Information	Prostate Cancer. The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Breast Cancer. The patient must be pre- or perimenopausal. The patient must have a diagnosis of hormone receptor (ER and/or PR +) positive breast cancer. Endometriosis. The patient must have a diagnosis of endometriosis AND only 3.6 mg dosage form is approved for use in endometriosis. Endometrial Thinning. The patient is scheduled for endometrial ablation AND only 3.6 mg dosage form is approved for use in endometrial thinning.
Age Restriction	Pediatric members less than 18 years old
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Endometriosis: 6 month. Endometrial Thinning: 2 month. All other indications: Plan year duration.
Other Criteria	
Part B Prerequisite	0

zoledronic acid-mannitol-water - IV SOLUTION, PIGGYBACK, BOTTLE (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Osteoporosis: The member has a diagnosis of osteoporosis. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance to any other oral bisphosphonate. Osteoporosis Prophylaxis in postmenopausal members: The member is postmenopausal. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance to any other oral bisphosphonate. Glucocorticoid induced Osteoporosis in men and women taking systemic glucocorticoids: Diagnosis of glucocorticoid induced osteoporosis or is either initiating or continuing systemic glucocorticoids with a daily dosage equivalent of 7.5 mg or greater of prednisone and is expected to remain on glucocorticoids for at least 12 months AND has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance to any other oral bisphosphonate . Paget's Disease: Diagnosis of Paget's disease. The member has continued elevation(s) in serum alkaline phosphatase (SAP) of two times or higher than the upper limit of normal despite previous treatment, contraindication, or intolerance to any other oral bisphosphonate. And the member: Is symptomatic OR is at risk for complications from their disease, to induce remission, or to normalize serum alkaline phosphatase. Brand Reclast request only: Members must have previous treatment, contraindication, or intolerance to generic Zoledronic acid (generic Reclast).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZOLINZA - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Cutaneous T-Cell Lymphoma (CTCL). The member has a diagnosis of progressive, persistent, or recurrent disease or The member will be using Zolinza (vorinostat) as primary treatment or adjuvant therapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZOLOFT - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZOMACTON - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	GH Therapy in Adults (18 or older). Must have previous tx with Omnitrope. Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary, hypothalamic disease, surgery, radiation, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (1 must be insulin tolerance test [ITT]). If contraindication to ITT, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, glucagon, and macimorelin test. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 5 ng/ml. Subnormal response to glucagon stimulation test is: Less than or equal to 3 mcg/L in patients with a BMI of less than 25 kg/m² OR Less than or equal to 3 mcg/L in patients with a BMI of 25 - 30 kg/m² and high pre-test probability, Less than or equal to 1 mcg/L in patients with a BMI of 25 - 30 kg/m² and a low pre-test probability OR Less than or equal to 1 mcg/L in patients with a BMI of greater than 30 kg/m². Subnormal response to the macimorelin test is defined as peak serum GH level less than or equal to 2.8 mcg/L. For ITT, blood glucose nadir of less than 40mg/dL must be documented. Certain patient subtypes (e.g. those with organic hypothalamic-pituitary disease and biochemical evidence of multiple pituitary hormone deficiencies (MPHD)) together with low-serum IGF-1 levels (less than -2.0 standard deviation score [SDS]) with genetic defects affecting the hypothalamic-pituitary axes, and hypothalamic-pituitary structural brain defects, can be diagnosed with adult GHD without performing GH-stimulation test. In patients with less than or equal to 2 pituitary hormone deficiencies, low-serum IGF-1 levels (less than -2.0 SDS) alone are not enough for a diagnosis of adult GHD, one GH-stimulation test is required to confirm the diagnosis.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration

ZOMACTON - VIAL (EA)

Other Criteria	GHT in Children (less than 18). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4, 7cm/yr for ages 2-4, 9 cm/yr for ages 1-2. Two GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex. Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic Renal insufficiency. Children with CRI and growth retardation who meet both: metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum AND At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age,sex). Prader-Willi Syndrome or Turner's Syndrome. Diagnosis of growth failure due to Prader-Willi syndrome OR Diagnosis of short stature associated with Turner's syndrome AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over 1 year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV measured over 1 year -2 SDS below the mean for age and sex). For Prader Willi Syndrome only: Is not severely obese or has a severe respiratory impairment . Noonan Syndrome. Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over 1 year prior to initiation of therapy of 1 or more SDS below the mean for age and sex.
Part B Prerequisite	0

ZONALON - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member has a diagnosis of atopic dermatitis or lichen simplex chronicus AND the member has had previous treatment with, contraindication, or intolerance to at least two of the following topical products: triamcinolone, mometasone, fluticasone cream, betamethasone, or clobetasol cream/ointment.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZONEGRAN - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZONISADE - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Partial-Onset (Focal) Seizures: Member has a diagnosis of partial-onset (focal) seizures AND Zonisade (zonisamide) will be used in combination with at least one other drug for controlling partial-onset seizures AND Member has tried or cannot use zonisamide capsules AND at least one other drug for controlling partial-onset seizures (e.g., levetiracetam, lamotrigine, carbamazepine, divalproex, gabapentin or topiramate).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZORYVE - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Plaque Psoriasis (Zoryve 0.3% topical cream): Diagnosis of chronic plaque psoriasis and ONE of the following: BSA involvement greater than or equal to 2% and has had previous treatment, contraindication, or intolerance with both a topical corticosteroid (e.g., triamcinolone 0.5% cream, betamethasone dipropionate) AND a topical vitamin D product (calcipotriene 0.005% cream) OR Prescriber determines that psoriasis impacts a sensitive part of the body (e.g., face, intertriginous areas) such that a topical corticosteroid would be inappropriate. Atopic Dermatitis (Zoryve 0.15% topical cream): The member has a diagnosis of mild to moderate atopic dermatitis (e.g. erythema that is faint pink to pink-red mild to moderate induration/papulation) AND The member has at least 5% affected body surface area (BSA) AND The member has had previous treatment, intolerance, or contraindication to one of the following topical products: triamcinolone, mometasone, betamethasone, or clobetasol OR The member has had previous treatment, intolerance, or contraindication to a topical calcineurin inhibitor (e.g. tacrolimus). Previous treatment with a calcineurin inhibitor is not required for children less than 2 years of age.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZORYVE - FOAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Seborrheic Dermatitis: Diagnosis of seborrheic dermatitis AND has had previous treatment, contraindication, or intolerance with both a topical corticosteroid (e.g, triamcinolone 0.1% cream, desonide 0.05% cream, Capex 0.01% topical shampoo) AND a topical antifungal (e.g. ketoconazole cream, ketoconazole foam, ciclopirox gel). Previous treatment with a topical antifungal is not required for children less than 12 years of age. Plaque Psoriasis: Diagnosis of chronic plaque psoriasis and ONE of the following: BSA involvement greater than or equal to 2% and has had previous treatment, contraindication, or intolerance with both a topical corticosteroid (e.g., triamcinolone 0.5% cream, betamethasone dipropionate) AND a topical vitamin D product (calcipotriene 0.005% cream) OR Prescriber determines that psoriasis impacts a sensitive part of the body (e.g., face, intertriginous areas) such that a topical corticosteroid would be inappropriate.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZOVIRAX - CREAM (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Recurrent herpes labialis (cold sores): Member has a diagnosis of recurrent herpes labialis (cold sores) AND the member has had previous treatment, contraindication, or intolerance with oral acyclovir and valacyclovir.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZOVIRAX - OINTMENT (GRAM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	The member must have a diagnosis of genital herpes OR member has a diagnosis of non-life-threatening mucocutaneous Herpes Simplex Virus (HSV) infection and is immunocompromised. The member has had previous treatment, contraindication, or intolerance with oral acyclovir and valacyclovir.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZOVIRAX - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZTALMY - SUSPENSION, ORAL (FINAL DOSE FORM)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Seizures associated with Cyclin-dependent Kinase-Like 5 (CDKL5) Deficiency Disorder (CDD): the member has a diagnosis of cyclin-dependent kinase-like 5 CDKL5) deficiency disorder (CDD).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZTLIDO - ADHESIVE PATCH, MEDICATED

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Herpetic Neuralgia (PHN): The member must have diagnosis of post-herpetic neuralgia AND the member has had previous treatment with generic lidocaine 5% patch. Chronic Back Pain: The member must have a diagnosis of chronic back pain AND the member has had previous treatment with generic lidocaine 5% patch. Pain associated with hip or knee osteoarthritis: the member must have a diagnosis of pain associated with hip or knee osteoarthritis AND the member has had previous treatment with generic lidocaine 5% patch.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZULRESSO - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Post-Partum Depression: The member is an adult with a clinical diagnosis of major depressive disorder (MDD) in the third trimester of pregnancy or within 4 weeks of delivery as defined by DSM-5 criteria and/or appropriate depression rating scale (e.g. HAM-D, MADRS, PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item). The member has previous treatment, contraindication, or intolerance to at least one antidepressant from the following: generic SSRI (e.g., citalopram, fluoxetine, paroxetine, or sertraline), SNRI (e.g., venlafaxine or duloxetine), bupropion OR mirtazapine OR physician attests with documentation that the severity of the depression would place the health of the mother or infant at significant risk. The member is not pregnant and not more than 6 months post-partum at initiation of Zulresso (brexanolone) therapy. The member is not experiencing active psychosis and does not have a history of bipolar disorders, schizophrenia, and/or schizoaffective disorder. The member has not attempted suicide in the current episode of postpartum depression.
Age Restriction	The member is at least 15 years of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	60 days duration
Other Criteria	
Part B Prerequisite	0

ZUNVEYL - TABLET, DELAYED RELEASE (ENTERIC COATED)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Alzheimer's Disease (mild to moderate): The member has a diagnosis of mild to moderate Alzheimer's disease AND The member has had prior therapy, contraindication or intolerance to at least TWO of the following medications: donepezil (i.e., donepezil tablets, orally disintegrating tablets, Adlarity), galantamine (i.e., galantamine tablets, oral solution, extended-release capsules), and rivastigmine (i.e. rivastigmine capsules, transdermal system).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZURZUVAE - CAPSULE

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Postpartum Depression. The member has a documented diagnosis of a major depressive episode as defined by DSM-5 criteria and severity as determined by an appropriate depression rating scale (e.g. HAM-D, MADRS, PHQ-9) with onset of symptoms in the third trimester of pregnancy or within 4 weeks of delivery AND The member will be receiving Zurzuvae therapy no later than one year postpartum AND The member is not pregnant at initiation of Zurzuvae therapy AND The member will be receiving no more than one 14-day course of treatment with Zurzuvae for the current episode of postpartum depression.
Age Restriction	The member is at least 18 years of age.
Prescriber Restriction	Licensed Practitioner
Coverage Duration	30 day duration
Other Criteria	
Part B Prerequisite	0

ZYDELIG - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	The member has experienced disease progression while on or following a PI3K inhibitor (e.g. idelalisib, copanlisib).
Required Medical Information	Chronic Lymphocytic Leukemia (CLL): The member must have a diagnosis of relapsed OR refractory chronic lymphocytic leukemia (CLL).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZYKADIA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Non-small Cell Lung Cancer (NSCLC): The member has a diagnosis of metastatic and documented anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC) AND the member has a medical reason as to why Alecensa (alectinib) OR Alunbrig (brigatinib) cannot be started or continued AND member will be using Zykadia (ceritinib) as monotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZYMFENTRA - PEN INJECTOR KIT (EA)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Ulcerative Colitis: The member has a diagnosis of moderately to severely active ulcerative colitis AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR The member has completed induction doses with an intravenous Infliximab product. Crohn's Disease: The member has a diagnosis of moderately to severely active Crohn's disease AND The member has had prior therapy, contraindication, or intolerance with TWO of the following: preferred adalimumab product [i.e. Humira (adalimumab), adalimumab-adbm, adalimumab-adaz], a preferred ustekinumab product (i.e., Stelara, Otulfi, Yesintek), Skyrizi, Rinvoq, or Tremfya OR The member has completed induction doses with an intravenous Infliximab product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	
Part B Prerequisite	0

ZYNLONTA - VIAL (EA)

PA Criteria	Criteria Details
Off-Label Uses	NA
Exclusion Criteria	Member experienced disease progression on Zynlonta (loncastuximab tesirine-lpyl).
Required Medical Information	B-cell Lymphoma: The member has a diagnosis of one of the following: diffuse large B-cell lymphoma (DLBCL) otherwise not specified, DLBCL arising from a low grade lymphoma (e.g. follicular lymphoma) OR a diagnosis of high-grade B-cell lymphoma (HGBL) not otherwise specified or with translocations AND The member has relapsed or refractory disease AND The member has had two or more lines of systemic therapy AND The member will be using Zynlonta as a single agent.
Age Restriction	NA
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan year duration
Other Criteria	NA
Part B Prerequisite	0

ZYNYZ - VIAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Anal carcinoma: Disease progression on previous anti-PD-1/PD-L1 therapy (e.g., pembrolizumab, nivolumab) AND For first line therapy: total treatment duration with Zynyz (retifanlimab-dlwr) is more than 12 months.
Required Medical Information	Merkel Cell Carcinoma: The member has a diagnosis of recurrent locally advanced or metastatic merkel cell carcinoma AND Zynyz (retifanlimab-dlwr) will be used as monotherapy. Anal carcinoma: The member has a diagnosis of inoperable locally recurrent or metastatic squamous cell carcinoma of the anal canal (SCAC) AND One of the following applies: Zynyz (retifanlimab-dlwr) will be used as first line therapy in combination with carboplatin and paclitaxel, followed by Zynyz (retifanlimab-dlwr) monotherapy OR Zynyz (retifanlimab-dlwr) will be used as a single agent after disease progression or intolerance to platinum-based chemotherapy.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Six months duration
Other Criteria	
Part B Prerequisite	0

ZYTIGA - TABLET

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	Prostate Cancer: Members with severe hepatic impairment (Child-Pugh Class C).
Required Medical Information	For brand Zytiga requests: Member must have an intolerance or contraindication to generic abiraterone acetate AND member must meet clinical criteria below. Prostate Cancer: One of the following applies: The member has metastatic castration-resistant prostate cancer (mCRPC) or The member has a diagnosis of castration-sensitive prostate cancer (CSPC) and The member will be using Zytiga (abiraterone acetate) in combination with a corticosteroid (prednisone, dexamethasone) and the member will use Zytiga (abiraterone acetate) in combination with androgen deprivation therapy (e.g. previous bilateral orchiectomy or luteinizing hormone-releasing hormone (LHRH) analog [i.e., LHRH agonist/ antagonist]).
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

ZYVOX - SUSPENSION, RECONSTITUTED, ORAL (ML)

PA Criteria	Criteria Details
Off-Label Uses	
Exclusion Criteria	
Required Medical Information	Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.
Age Restriction	
Prescriber Restriction	Licensed Practitioner
Coverage Duration	Plan Year Duration
Other Criteria	
Part B Prerequisite	0

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

PART B VERSUS PART D

Products Affected

- Akynzeo (netupitant) 300 mg-0.5 mg capsule
- Aprepitant 125 mg (1)-80 mg (2) capsules in a dose pack
- Astagraf XL 0.5 MG; 1 MG; 5 MG; capsule, extended release
- azathioprine 100 MG; 50 MG; 75 MG; tablet
- CellCept 200 MG/ML; 250 MG; 500 MG; oral suspension
- CellCept Intravenous 500 MG; intravenous solution
- Compazine 10 MG; 5 MG; tablet
- cyclophosphamide 25 MG; 50 MG; tablet
- cyclosporine modified 100 MG; 100 MG/ML; 25 MG; 50 MG; capsule
- dronabinol 10 MG; 2.5 MG; 5 MG; capsule
- Emend 125 mg (1)-80 mg (2) capsules in a dose pack
- Envarsus XR 0.75 MG; 1 MG; 4 MG; tablet, extended release
- Gengraf 100 MG; 100 MG/ML; 25 MG; capsule
- granisetron HCl 1 MG; tablet
- Jylamvo 2 MG/ML; oral solution
- Medrol 16 MG; 2 MG; 4 MG; 8 MG; tablet
- methylprednisolone 16 MG; 32 MG; 4 MG; 8 MG; tablet
- mycophenolate 500 MG; intravenous solution
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; oral powder for suspension
- mycophenolate sodium 180 MG; 360 MG; tablet, delayed release
- Anzemet 50 MG; tablet
- Aprepitant 125 MG; 125 mg (1)- 80 MG (2); 40 MG; 80 MG; capsule
- Azasan 100 MG; 75 MG; tablet
- CellCept 200 MG/ML; 250 MG; 500 MG; capsule
- CellCept 200 MG/ML; 250 MG; 500 MG; tablet
- chlorpromazine 10 MG; 25 MG; tablet
- cyclophosphamide 25 MG; 50 MG; capsule
- cyclosporine 100 MG; 25 MG; capsule
- cyclosporine modified 100 MG; 100 MG/ML; 25 MG; 50 MG; oral solution
- Emend 125 mg (1)- 80 MG (2); 125 mg (25 mg/ ML FINAL CONC.); 80 MG; capsule
- Emend 125 mg (25 mg/mL final conc.) oral suspension
- everolimus (immunosuppressive) 0.25 MG; 0.5 MG; 0.75 MG; 1 MG; tablet
- Gengraf 100 MG; 100 MG/ML; 25 MG; oral solution
- Imuran 50 MG; tablet
- Marinol 10 MG; 2.5 MG; 5 MG; capsule
- methotrexate sodium 2.5 MG; tablet
- Millipred 5 MG; tablet
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; capsule
- mycophenolate mofetil 200 MG/ML; 250 MG; 500 MG; tablet
- Myfortic 180 MG; 360 MG; tablet, delayed release

- Myhibbin 200 MG/ML; oral suspension
- Neoral 100 MG; 100 MG/ML; 25 MG; oral solution
- ondansetron HCl 4 MG; 4 MG/5 ML; 8 MG; oral solution
- Orapred ODT 10 MG; 15 MG; 30 MG; disintegrating tablet
- prednisolone 10 MG; 10 MG/5 ML; 15 MG; 15 mg/5 mL (3 MG/ML); 15 MG/5 ML (5 ML); 20 mg/5 mL (4 MG/ML); 25 mg/5 mL (5 MG/ML); 30 MG; 5 mg base/5 mL (6.7 MG/5 ML); disintegrating tablet
- prednisolone 15 MG/5 ML; 5 MG; tablet
- prednisolone sodium phosphate 10 MG; 10 MG/5 ML; 15 MG; 15 mg/5 mL (3 MG/ML); 15 MG/5 ML (5 ML); 20 mg/5 mL (4 MG/ML); 25 mg/5 mL (5 MG/ML); 30 MG; 5 mg base/5 mL (6.7 MG/5 ML); oral solution
- prednisone 1 MG; 10 MG; 2 MG; 2.5 MG; 20 MG; 5 MG; 5 MG/5 ML; 50 MG; tablet
- Prednisone Intensol 5 MG/ML; oral concentrate
- Prograf 0.2 MG; 0.5 MG; 1 MG; 5 MG; capsule
- Rapamune 0.5 MG; 1 MG; 1 MG/ML; 2 MG; oral solution
- Rayos 1 MG; 2 MG; 5 MG; tablet,delayed release
- Sandimmune 100 MG; 100 MG/ML; 25 MG; oral solution
- sirolimus 0.5 MG; 1 MG; 1 MG/ML; 2 MG; tablet
- tacrolimus 0.5 MG; 1 MG; 5 MG; capsule, immediate-release
- Trexall 10 MG; 15 MG; 5 MG; 7.5 MG; tablet
- Varubi 90 MG; tablet
- Xatmep 2.5 MG/ML; oral solution
- Neoral 100 MG; 100 MG/ML; 25 MG; capsule
- ondansetron 16 MG; 4 MG; 8 MG; disintegrating tablet
- ondansetron HCl 4 MG; 4 MG/5 ML; 8 MG; tablet
- Pediapred 5 mg base/5 mL (6.7 MG/5 ML); oral solution
- prednisolone 15 MG/5 ML; 5 MG; oral solution
- prednisolone sodium phosphate 10 MG; 10 MG/5 ML; 15 MG; 15 mg/5 mL (3 MG/ML); 15 MG/5 ML (5 ML); 20 mg/5 mL (4 MG/ML); 25 mg/5 mL (5 MG/ML); 30 MG; 5 mg base/5 mL (6.7 MG/5 ML); oral soln
- prednisone 1 MG; 10 MG; 2 MG; 2.5 MG; 20 MG; 5 MG; 5 MG/5 ML; 50 MG; oral solution
- prednisone 1 MG; 10 MG; 2 MG; 2.5 MG; 20 MG; 5 MG; 5 MG/5 ML; 50 MG; tablet,delayed release
- prochlorperazine maleate 10 MG; 5 MG; tablet
- Prograf 0.2 MG; 0.5 MG; 1 MG; 5 MG; oral granules in packet
- Rapamune 0.5 MG; 1 MG; 1 MG/ML; 2 MG; tablet
- Sandimmune 100 MG; 100 MG/ML; 25 MG; capsule
- sirolimus 0.5 MG; 1 MG; 1 MG/ML; 2 MG; oral solution
- Syndros 5 MG/ML; oral solution
- tacrolimus XL 0.5 MG; 1 MG; 5 MG; capsule,extended release 24 hr
- trimethobenzamide 300 MG; capsule
- Veripred 20 20 mg/5 mL (4 MG/ML); oral solution
- Zortress 0.25 MG; 0.5 MG; 0.75 MG; 1 MG; tablet

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتيسيق البديل مجانًا. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Չանգահարե՛ք՝ **877-320-1235 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]: 我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235 (听障专线: 711)**。

繁體中文 [Traditional Chinese]: 我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235 (聽障專線: 711)**。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòm sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **877-320-1235 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિ:શુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કોલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**.

हिन्दी [Hindi]: नि:शुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY: 711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **877-320-1235 (TTY: 711)**.

This notice is available at <http://www.humana.com/legal/multi-language-support>.

日本語 [Japanese]: 言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជំនួយផ្សេងៗដល់អ្នកមានការពិការភាព។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)**។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다.
877-320-1235 (TTY: 711)번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີການບໍລິການດ້ານພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນໃຫ້ໃຊ້ພຣິ.
ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad t'áa' jiik'eh, t'áadoole'é binahji' bee adahodoonílgíí diné bich'í' anídahazt'i'í, dóó łahgo át'éeego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohji' hodílnih **877-320-1235 (TTY: 711)**.

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **877-320-1235 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ **(TTY: 711) 877-320-1235**

Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]: ቋንቋ፣ ኢንተር ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችን ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bàsà [Bassa]: Wuḍu-xwíníín-mú-zà-zà kùà, Hwòdǒ-fańa-nyo, kè nyo-boŭn-po-kà bě bé nyuεε se wídí p'éè-p'éè dǒ ko. **877-320-1235 (TTY: 711)** dá.

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn isẹ àtilẹhìn ìrànጓwọ èdè, àti ọ̀nà kíkà mírán wà lárọ̀wọ̀tọ́. Pe **877-320-1235 (TTY: 711)**.