Products Affected: acarbose tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Actemra SC

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For Rheumatoid Arthritis: Trial of etanercept (Enbrel) or adalimumab (Humira) ineffective, contraindicated or not tolerated. For Giant Cell Arteritis: diagnosis confirmed by temporal artery biopsy. For Initial Therapy, member meets ONE of the following: • Giant cell arteritis has relapsed while on corticosteroids, OR • Corticosteroids are unable to achieve remission, OR • Member has experienced unacceptable adverse effects with corticosteroids. For continuing therapy with diagnosis of Giant cell arteritis, member must require continued use of Actemra SC to prevent relapse of giant cell arteritis.
Age Restrictions	
Prescriber Restrictions	For Rheumatoid Arthritis: prescribed by a Rheumatology Specialist For Giant Cell Arteritis: prescribed by, or in consultation with, a Rheumatologist.
Coverage Duration	One year for both initial and continuing therapy
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Acthar Gel

PA criteria	Criteria Details
Covered uses	Infantile Spasms
Exclusion criteria	
Required Medical information	Member is less than 2 years of age and confirmed absence of congenital infections.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a Neurologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Actimmune injection

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: adapalene cream, adapalene gel (eq Differin), adapalene/benzoyl peroxide gel 0.1/2.5% (generic Epiduo) and Epiduo Forte 0.3/2.5%, Differin OTC Gel 0.1%

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of acne vulgaris
Age Restrictions	Members age 35 or older require prior authorization
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Adempas

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	1) Patient is taking a nitrate or nitric oxide donor medication (e.g., amyl nitrite) on a regular or intermittent basis. 2) Patient is taking a phosphodiesterase inhibitors (e.g., sildenafil, tadalafil, vardenafil)
Required Medical information	Diagnosis confirmed by right heart catheterization
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	One year
Other Criteria	For diagnosis of Pulmonary Arterial Hypertension (WHO Group 1), intolerance to, or failure of, one of the following: ambrisentan (eq Letairis), bosentan (eq Tracleer) or macitentan (Opsumit). For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required. Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Afinitor tablet, everolimus tablet

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with a Neurologist or an Oncologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Aimovig

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial approval: Member has greater than or equal to 4 migraine days per month for the previous 3 months or longer AND has documentation of trial and failure of a 3-month or greater trial of one of the following medications: topiramate, divalproex DR or ER, propranolol or timolol tablets. Will not be used concomitantly with onabotulinumtoxinA (Botox). Continuation: Member must have documented improvement in frequency and/or severity of migraine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	

Products Affected: Ajovy Injection

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial approval-Member has greater than or equal to 4 migraine days per month for the previous 3 months or longer AND had documentation of trial and failure of a 3-month or greater trial of one of the following medications: topiramate, divalproex DR or ER, propranolol or timolol tablets. Will not be used concomitantly with onabotulinumtoxin A (Botox). Continuation: Member must have documented improvement in frequency and/or severity of migraine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Akynzeo cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Alecensa

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Alferon-N inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Alinia tab, Alinia Suspension, nitazoxanide tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Giardiasis requires a trial of metronidazole or tinidazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to length of therapy requested and approved
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Alkindi

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Prescribed as replacement therapy in a pediatric member with adrenocortical insufficiency. Member is unable to swallow tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: alosetron

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	• Do not initiate in patients with constipation • History of chronic or severe constipation or sequelae from constipation; intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions; ischemic colitis; impaired intestinal circulation, thrombophlebitis, or hypercoagulable state; Crohn's disease or ulcerative colitis; diverticulitis; severe hepatic impairment • Concomitant use of fluvoxamine
Required Medical information	Women with severe diarrhea-predominant irritable bowel syndrome (IBS) who have: • chronic IBS symptoms (generally lasting 6 months or longer), • had anatomic or biochemical abnormalities of the gastrointestinal tract excluded, and • not responded adequately to conventional therapy. Severe IBS includes diarrhea and 1 or more of the following: • frequent and severe abdominal pain/discomfort, • frequent bowel urgency or fecal incontinence, • disability or restriction of daily activities due to IBS.
Age Restrictions	Age 18 or older
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Alunbrig tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Endothelin Receptor Antagonists: ambrisentan, Opsumit, bosentan, Tracleer

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization and NYHA Functional Class II or III symptoms for ambrisentan, and Opsumit and NYHA Functional Class II-IV symptoms for bosentan.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Amitiza ,lubiprostone

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Not indicated for IBS-C in men
Required Medical information	Trial and failure of polyethylene glycol (Miralax/Glycolax)
Age Restrictions	Age 18 and above
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Amjevita

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For moderate to severe **Rheumatoid Arthritis**: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For **Juvenile Idiopathic Arthritis**: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For **Plaque Psoriasis**: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR acitretin (Soriatane). For **Psoriatic Arthritis**: Requires failure of, or intolerance to methotrexate. For **Ulcerative Colitis or Crohn's Disease**: Requires failure of, or intolerance to one of the following: corticosteroid, azathioprine, OR 6-mercaptopurine. For **Hidradenitis Suppurativa (HS):** patient must have at least 3 cysts AND failure of therapy with at least one (1) oral antibiotic.
Age Restrictions	
Prescriber Restrictions	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis and Hidradenitis Suppurativa (HS): Prescribed by, or in consultation with a Dermatology Specialist. For Crohn's Disease and Ulcerative Colitis: Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	One year
Other Criteria	

Products Affected: aprepitant

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	None.

Products Affected: Arikayce Inh Susp

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of *Mycobacterium avium* complex lung disease. Failed to achieve negative sputum cultures after ≥ 6 consecutive months of multidrug regimen therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an infectious disease or pulmonary specialist
Coverage Duration	Six months
Other Criteria	

Products Affected: armodafinil tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Balversa tablets

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of locally advanced or metastatic urothelial carcinoma. • Documentation of the presence of susceptible FGFR3 or FGFR2 genetic alterations as detected by an FDA-approved test • Trial of platinum-containing chemotherapy was ineffective ○ Progression occurred during or following, including within 12 months of neoadjuvant or adjuvant chemotherapy
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Banzel suspension , rufinamide suspension

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Trial of a least one anti-epileptic medication was ineffective or not tolerated.
Age Restrictions	
Prescriber Restrictions	Prescribed by a neurologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Baraclude oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For patients age 2 years and older, must provide a valid medical reason as to why the patient cannot take entecavir in a solid dosage form
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Baxdela 400 mg tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Infectious Disease Specialist
Coverage Duration	Up to 6 months
Other Criteria	

Products Affected: bexarotene capsules

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology or Dermatology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: bexarotene gel (Targretin equiv)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology or Dermatology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Bosulif tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Brukinsa

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of mantle cell lymphoma Relapsed/refractory to at least 1 prior line of therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist
Coverage Duration	One year
Other Criteria	

Products Affected: Cabometyx tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Calquence

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an oncologist or hematologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: capecitabine tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Caprelsa

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or Endocrinologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: carglumic acid

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: CaroSpir oral susp, spironolactone suspension

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For patients age 9 and older, must provide a valid medical reason as to why the patient cannot take spironolactone in a solid dosage form
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Cayston inhalation soln

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with Infectious Disease or Pulmonary Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Cimzia inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For RA, Psoriatic Arthritis, and Ankylosing Spondylitis: Trial of etanercept (Enbrel) or adalimumab (Humira) ineffective, contraindicated or not tolerated. For Crohn's disease: A trial of adalimumab (Humira) was ineffective, contraindicated, or not tolerated. For moderate to severe Plaque Psoriasis: requires trial of Enbrel, Humira or Otezla. Continuing therapy requires that member has demonstrated a significant improvement in their condition. Documentation of improvement within the past year (written explanation accepted) must be submitted with the request for continuation.
Age Restrictions	
Prescriber Restrictions	For RA, Psoriatic Arthritis, Ankylosing Spondylitis or active non-radiographic axial spondyloarthritis with objective signs of inflammation: Prescribed by a Rheumatology Specialist. For Crohn's Disease: Prescribed by a Gastroenterology Specialist. For moderate to severe Plaque Psoriasis: Prescribed by a Dermatologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: clobazam (Onfi)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: clobetasol topical lotion

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Patient must try/fail or be intolerant to one less potent formulary alternative (medium or high) potency topical steroid such as fluticasone propionate, fluocinolone acetonide, triamcinolone, betamethasone valerate, augmented betamethasone, mometasone furoate,or desoximetasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Cometriq

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Copiktra capsules

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of relapsed/refractory CLL or SLL Trial and failure of ≥ 2 prior therapies Continuation: patient is being monitored and has not experienced progression on Copiktra and it is appropriate for them to continue therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Corlanor

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	a) The patient has NYHA Class II-IV or ACCF/AHA Class C, D chronic heart failure b) The patient has a baseline OR current LVEF ≤ 35% c) The patient is in sinus rhythm with a resting heart rate ≥ 70 beats per minute (bpm) d) One of the following: i) The patient is on a maximally tolerated dose of beta blocker (e.g. atenolol, bisoprolol, carvedilol, metoprolol) OR ii) The patient has a history of a documented intolerance, FDA labeled contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Cotellic tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: cyclophosphamide capsules

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Cystadane Powder

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: deferasirox granules packet (Jadenu equiv); deferasirox tablet 90mg, 360mg tablet (Jadenu equiv); deferasirox tablet (Exjade equiv)

PA criteria	**Criteria Details**
Covered uses	All FDA-approved indications
Exclusion criteria	) Serum creatinine greater than 2 times the age-appropriate upper limit of normal (ULN) or creatinine clearance less than 40mL/min.) Patients with poor performance status.) Patients with high-risk myelodysplastic syndromes (MDS).) Patients with advanced malignancies) Patients with platelet counts less than 50,000/mm3
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to Hematology Specialist or in consultation with Hematology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: deferiprone tablet, and Ferriprox Solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to Hematology Specialist or in consult with Hematology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Descovy Tablet

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For pre-exposure prophylaxis of HIV infection: Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: • Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval) • Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: diclofenac gel 3%

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Doptelet tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For thrombocytopenia with chronic liver disease and scheduled to undergo a procedure: Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter.
Age Restrictions	
Prescriber Restrictions	For chronic immune thrombocytopenia: Prescribed by, or in consultation with a Hematologist.
Coverage Duration	One year
Other Criteria	

Products Affected: Dupixent injection

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	1. Diagnosis of chronic severe atopic dermatitis (eczema) at baseline • ≥ 10% BSA affected (with the exception of involvement in sensitive areas. Would require chart note documentation of severity) • Level of severity documented via ONE of the following: SCORAD with a score of ≥ 40 OR Eczema Area and Severity Index (EASI) score of ≥ 21 OR Submission of supporting documentation of continued disease severity and impaired activities of daily living while on most successful treatment regimen. Required documentation of trial and failure of one the following: • Medium to very high potency topical steroid or • Topical calcineurin inhibitor or • Narrow Band UVB Phototherapy or • Immunosuppressant or relative contraindication (cyclosporine, azathioprine, methotrexate or mycophenolate mofetil) 2. Used as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 6 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma. Must also provide documentation of a baseline blood eosinophil concentration ≥ 150 cells/mcL. 3. Used as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis. • Greater than 12-week duration • Bilateral nasal polyposis confirmed by sinus CT scan • Trial of oral and nasal steroids • Documentation of moderate to severe symptoms of nasal congestion, blockage or obstruction (such as loss of smell, rhinorrhea, or facial pain). 4. Eosinophilic esophagitis requires documentation of an endoscopic biopsy with ≥ 15 eosinophils/high power field and symptoms of esophageal dysfunction. Trial of a proton pump inhibitor or a topical corticosteroid was ineffective, not tolerated, or contraindicated. corticosteroid. 5. Treatment of adult patients with Prurigo nodularis.
Age Restrictions	Chronic rhinosinusitis with nasal polyposis: age 18 or older Asthma: age 6 years or older

	Atopic dermatitis: age 6 months or older Eosinophilic esophagitis: age 12 years and older
Prescriber Restrictions	Prescribed by or in consultation with an allergy specialist, pulmonary specialist, immunologist, dermatologist, gastroenterologist or otolaryngologist.
Coverage Duration	One year
Other Criteria	Continuation Criteria: Documentation with chart notes of positive clinical response

Products Affected: Egrifta inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Contraindicated in patients with disruption of the hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, head irradiation or head trauma. Contraindicated in patients with active malignancy (either newly diagnosed or recurrent). Any preexisting malignancy should be inactive and its treatment complete prior to instituting therapy. Pregnancy.
Required Medical information	Males must have a waist circumference of at least 95cm (37.5in) and a waist-to-hip ratio of at least 0.94. Females must have a waist circumference of at least 94cm (37in) and a waist-to-hip ratio of at least 0.88. Patients must have a baseline CT documenting increased visceral adipose tissue (VAT). The patient does not have a diagnosis of diabetes mellitus or a fasting blood glucose of >150 mg/dL Reauthorization is contingent upon ONE of the following: 1) decrease in VAT measured by CT scan or 2) reduction of waist circumference and waist-to-hip ratio from baseline measurement
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must be on a stable antiretroviral regimen for at least 8 weeks. Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Emgality 100mg/ml

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial approval: Diagnosis of episodic cluster headache AND has documentation of trial and failure of a 3-month or greater trial of verapamil. Continuation: Member must have documented improvement in frequency and/or severity of episodic cluster headache. Quantity Limit: 3 injections/fill, 6 fills/year
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	

Products Affected: Emgality 120mg/ml

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial approval: Member has greater than or equal to 4 migraine days per month for the previous 3 months or longer AND has documentation of trial and failure of a 3-month or greater trial of one of the following medications: topiramate, divalproex DR or ER, propranolol or timolol tablets. Will not be used concomitantly with onabotulinumtoxinA (Botox). Continuation: Member must have documented improvement in frequency and/or severity of migraine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	

Products Affected: Empaveli

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial: Must have received vaccination against encapsulated bacteria within 2 years before treatment or will receive vaccination at least 14 days before treatment initiation. Diagnosis of PNH confirmed by flow cytometry and LDH (documentation required). − GPI-AP deficient red blood cells and polymorphonuclear leukocytes >50% − LDH ≥ 1.5 times the upper limit of normal Age ≥ 18 years Continuation: Documentation of a positive response or improvement − Reduction in transfusions − Improvement in fatigue/quality of life
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or immunology specialist.
Coverage Duration	Initial: 6 months Continuation: 1 year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: enalapril (eq Epaned) oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Contraindicated if history of angioedema related to previous treatment with an ACE inhibitor; hereditary or idiopathic angioedema; co-administration with aliskiren (Tekturna) in patients with diabetes.
Required Medical information	Must provide a valid medical reason as to why the patient cannot take an enalapril in a solid dosage form
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Enbrel

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Active infection.
Required Medical information	For moderate to severe Rheumatoid Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For Juvenile Idiopathic Arthritis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For Plaque Psoriasis: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR acitretin (Soriatane). For Psoriatic Arthritis: Requires failure of, or intolerance to methothrexate.
Age Restrictions	
Prescriber Restrictions	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	One year
Other Criteria	For members with a diagnosis of early, severe-onset RA, additional required medical information is not required.

Products Affected: Enspryng inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of NMOSD Documentation is provided of a positive test for anti-aquaporin-4 antibodies. Continuation criteria: positive clinical response from baseline.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist, ophthalmologist, or neuro-ophthalmologist.
Coverage Duration	Initial: six months Continuation: One year
Other Criteria	Will not be used in combination with eculizumab (Soliris) or inebilizumab (Uplizna).

Products Affected: Epidiolex oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	• Diagnosis of Lennox-Gastaut syndrome or Dravet syndrome • Currently taking ≥ 1 AED at a stable dose (which will be continued with Epidiolex) • Trial of ≥ 1 AED was ineffective, contraindicated or not tolerated
Age Restrictions	Must be 1 years of age or older
Prescriber Restrictions	Prescribed by a neurologist
Coverage Duration	One year
Other Criteria	

Products Affected: Erivedge

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: erlotinib tab, Tarceva tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Esbriet, pirfenidone, Ofev

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For idiopathic pulmonary fibrosis: Diagnosis confirmed by both of the following: A) No known cause of lung fibrosis AND B) One of the following: 1) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) 2) High-resolution computed tomography (HRCT) indicates definite UIP pattern 3) Both HRCT indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. **OR** (for Ofev only) Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) or chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist, pulmonologist, or rheumatologist.
Coverage Duration	One year
Other Criteria	Will not be used in combination with other medications used to treat IPF

Products Affected: Etoposide capsules

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Evrysdi oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation is provided of a genetic test confirming diagnosis of spinal muscular atrophy. Genetic confirmation of a bi-allelic SMN1 gene deletion Baseline exam including one of the following assessments • Children Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) • Hammersmith Function Motor Scale Expanded (HFMSE) • Hammersmith Infant Neurological Examination Part 2 (HINE-2) • Revised Upper Limb Module (RULM) Test Continuation: Documentation of continued benefit from medication
Age Restrictions	
Prescriber Restrictions	Prescribed by a neurologist.
Coverage Duration	One year
Other Criteria	Will not be used in combination with nusinersen (Spinraza).

Products Affected: Fasenra

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of one (1) or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s).
Age Restrictions	Member must be 12 years of age or older.
Prescriber Restrictions	Prescribed by, or in consultation with an Allergy Specialist, Immunologist, or Pulmonary Specialist.
Coverage Duration	One year
Other Criteria	

Products Affected: fentanyl citrate lollipop

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Contraindications: • Opioid non-tolerant patients. Patients considered opioid tolerant are those who are taking at least 60 mg oral morphine/day, or at least 25 mcg transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer. • Management of acute or postoperative pain including headache/migraines or dental pain.
Required Medical information	
Age Restrictions	16 years of age and older
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For diagnosis of management of breakthrough pain in patients with cancer who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. Patients must require and use around-the-clock opioids.

Products Affected: Fleqsuvy Suspension, baclofen suspension, Lyvispah Granule Packet

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Forteo, teriparatide

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Member has had at least 1 fracture or member has BMD screening results -2.5 or below, AND member has previously used and failed a bisphosphonate. Documented recent calcium and Vitamin D levels
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Treatment duration: Use of FORTEO for more than 2 years during a patient's lifetime is not recommended.

Products Affected: Fulphila

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Do not administer between 14 days before and 24 hours after administration of cytotoxic chemotherapy.

Products Affected: Galafold capsules

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of Fabry Disease Must have an amenable GLA (glactosidase alpha) gene variant documented by clinical genetics professional
Age Restrictions	Must be 18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a medical geneticist or other prescriber specialized in the treatment of Fabry disease
Coverage Duration	One year
Other Criteria	

Products Affected: Gattex

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of short bowel syndrome. Dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary. For continuation of therapy, documentation of at least a 20% reduction in parenteral support since the initiation of Gattex therapy is required.

Products Affected: Gilotrif tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: halcinonide cream

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation of failure, intolerance, or contraindication to betamethasone dipropionate 0.05% (Diprosone equiv, Diprolene AF equiv), desoximetasone 0.25% (Topicort equiv), fluocinonide 0.05% (Lidex equiv) or halobetasol propionate 0.01% (Ultravate equiv)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Hemlibra

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	**Initial criteria:** • Diagnosis of Hemophilia A (congenital Factor VIII deficiency) **Renewal criteria:** • Documentation of positive clinical response to therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	One year (initial and renewal)
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Hizentra inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Humira, Adalimumab-adaz, Adalimumab-adaz pfs, Adalimumab-fkjp, Hadlima

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For moderate to severe **Rheumatoid Arthritis**: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 20mg/wk. For **Juvenile Idiopathic Arthritis**: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15 mg/week. For **Plaque Psoriasis**: Requires failure of, or intolerance to therapy with methotrexate at a dose of at least 15mg/week OR acitretin (Soriatane). For **Psoriatic Arthritis**: Requires failure of, or intolerance to methotrexate. For **Ulcerative Colitis or Crohn's Disease**: Requires failure of, or intolerance to one of the following: corticosteroid, azathioprine, OR 6-mercaptopurine. For **Hidradenitis Suppurativa (HS):** patient must have at least 3 cysts AND failure of therapy with at least one (1) oral antibiotic. For **Uveitis:** Requires failure of, or intolerance to therapy with a corticosteroid AND an immunosuppressant (methotrexate, mycophenolate mofetil, athioprine, OR cyclosporine).
Age Restrictions	
Prescriber Restrictions	For Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Plaque Psoriasis and Hidradenitis Suppurativa(HS): Prescribed by, or in consultation with a Dermatology Specialist. For Crohn's Disease and Ulcerative Colitis: Prescribed by, or in consultation with a Gastroenterology Specialist. For Uveitis: Prescribed by, or in consultation with a Rheumatology specialist OR ophthalmologist.
Coverage Duration	One year
Other Criteria	

Products Affected: Hycamtin capsule

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Hyqvia

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of primary immunodeficiency such as: agammaglobulinemia due to absence of B cells, hypogammaglobulinemia, normal immunoglobulins with poor antibody function or a genetically defined primary immunodeficiency disease and one of the following: • Inadequate responsiveness to specific antigens (ex: pneumococcal polysaccharide) • History of recurrent significant infection
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, allergist or immunologist
Coverage Duration	One year
Other Criteria	

Products Affected: Ibrance

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Iclusig tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Imbruvica

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or under the direct consultation, of an Oncologist, Hematologist or transplant specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Increlex inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Inlyta

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Inqovi tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist
Coverage Duration	One year
Other Criteria	

Products Affected: Intron-A inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Iressa tab, gefitinib

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Jakafi tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology or Hematology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Katerzia oral susp

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For patients age 6 and older, must provide a valid medical reason as to why the patient cannot take amlodipine in a solid dosage form
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Kerendia

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Trial of Farxiga not tolerated or contraindicated
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Kevzara inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Member has a diagnosis of Rheumatoid Arthritis and trial of etanercept (Enbrel) or adalimumab (Humira) ineffective, contraindicated or not tolerated.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Rheumatology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Korlym tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Contraindications: · Pregnancy · Use of simvastatin or lovastatin and CYP3A substrates with narrow therapeutic range · Concurrent long-term corticosteroid use · Women with history of unexplained vaginal bleeding · Women with endometrial hyperplasia with atypia or endometrial carcinoma
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an endocrinologist
Coverage Duration	One year
Other Criteria	Do not use for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing's syndrome

Products Affected: Kynmobi

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation of continued “off” episodes despite treatment with carbidopa/levodopa in combination with rasagiline or entacapone
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Lampit

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Serologically confirmed T. cruzi infection. Patient does not have congestive heart failure (Kuschnir Class III) due to Chagas cardiomyopathy.
Age Restrictions	Age of patient is less than or equal to 18 years of age and weighing greater than 2.5kg
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist
Coverage Duration	60 days
Other Criteria	

Products Affected: lapatinib tab, Tykerb tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	• Prescribed in combination with capecitabine (Xeloda) AND the patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND the patient has received prior therapy including an anthracycline and a taxane and trastuzumab (Herceptin). • Prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor-positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.
Age Restrictions	
Prescriber Restrictions	Approval requires the prescriber to be an Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Lazanda nasal spray

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Contraindications: • Opioid non-tolerant patients. Patients considered opioid tolerant are those who are taking at least 60 mg oral morphine/day, or at least 25 mcg transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer. • Management of acute or postoperative pain including headache/migraines or dental pain.
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For diagnosis of management of breakthrough pain in patients with cancer who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. Patients must require and use around-the-clock opioids.

Products Affected: Lenvima

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: lidocaine/prilocaine cream 2.5%/2.5%

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Prescribed as a topical anesthetic for use on normal intact skin for local analgesia or genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: linezolid

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease Specialist or in consultation with an Infectious Disease Specialist
Coverage Duration	Up to length of therapy requested and approved
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Linzess

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Trial and failure of polyethylene glycol (Miralax/Glycolax)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Livtencity

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Livtencity will not be used or cytomegalovirus prophylaxis.
Required Medical information	Member received a Hematopoietic stem cell transplant or solid organ transplant AND has a diagnosis of active cytomegalovirus infection or disease AND member has experienced significant intolerance to , or their infection or disease is refractory to treatment with ganciclovir, valganciclovir, cidofovir, or fascarnet.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a transplant or infectious disease specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Lokelma powder for suspension

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Hyperkalemia (greater than 5.0 mmol/L) persists despite both of the following: Dietary management and use of diuretics (if appropriate)
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Nephrologist, Cardiologist or Endocrinologist
Coverage Duration	One year
Other Criteria	

Products Affected: Lonsurf

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	a) Patient previously treated with all of the following: i) Fluoropyrimidine-based chemotherapy (fluorouracil or capecitabine) ii) Oxaliplatin-based chemotherapy iii) Irinotecan-based chemotherapy iv) Anti-VEGF therapy (such as bevacizumab) b) If patient is RAS wild-type, patient has received treatment with an anti-EGFR therapy (cetuximab or panitumumab). Documentation of RAS testing required c) Documentation of current ECOG status requested (not required for authorization)
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Lorbrena tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For ALK + NSCLC: • Diagnosis of ALK-positive metastatic NSCLC • Trial of alectinib (Alecensa), brignatinib (Alunbrig) or ceritinib (Zykadia) was ineffective, contraindicated or not tolerated. For ROS1 + NSCLC: • Diagnosis of ALK-positive metastatic NSCLC • Trial of Xalkori (crizotinib) or ceritinib (Zykadia) was ineffective, contraindicated or not tolerated. Continuation: patient is being monitored, has not experienced disease progression, and is appropriate to continue therapy with Lorbrena.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	One year
Other Criteria	Documentation of the presence of the mutation as detected by an FDA-approved test

Products Affected: Lumakras

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial approval: Documentation of the KRAS G12C-mutation and received at least one prior systemic therapy Continuation: Member is being monitored, has not experienced disease progression, and is appropriate to continue therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Lynparza cap, Lynparza tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Matulane cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Mavyret tab, Mavyret Pak

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Required Medical Info: 1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.
Age Restrictions	Patient must be 3 years of age or older.
Prescriber Restrictions	Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.
Coverage Duration	Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected: Mekinist tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	➢ Indicated as a single agent for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations. ➢ Indicated, in combination with dabrafenib (Tafinlar), for: o the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test. o the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test, and involvement of lymph node(s), following complete resection. o the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test. o the treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options o The treatment of solid tumor (unresectable or metastatic) in combination with Tafinlar with BRAF V600E mutation, as detected by an FDA approved test.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	One year
Other Criteria	MEKINIST is not indicated for treatment of patients with melanoma who have progressed on prior BRAF-inhibitor therapy

Products Affected: miglustat (Zavesca) cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of mild/moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Clinical Geneticist, Medical Biochemical Geneticist, Hematologist, or Metabolic Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: modafinil tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Movantik tablets

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial Therapy: 1) Opioid induced constipation and 2) Failed one laxative/bowel therapy --polyethylene glycol or lactulose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 Months for initial approval, one year on extension request
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Myfembree

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	No known osteoporosis, patient is premenopausal & a trial of hormonal contraceptives was ineffective, contraindicated, or not tolerated.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an obstetrician-gynecologist or other women's health reproductive specialist
Coverage Duration	Approval duration: 24 months (no renewal)
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Myleran tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: naproxen/esomeprazole DR tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, or juvenile idiopathic arthritis Failure, intolerance, or contraindication to an NSAID taken in combination with a PPI or clinical reason that patient is unable to use individual products (naproxen and esomeprazole) in combination provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Nerlynx tab (limited distribution: Diplomat Specialty Pharmacy)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Neulasta Onpro

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Do not administer between 14 days before and 24 hours after administration of cytotoxic chemotherapy.

Products Affected: Nexletol, Nexlizet

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	LDL-C greater than or equal to 70mg/dL (while on ezetimibe & maximally tolerated statin, or member is statin intolerant) and will be taken with maximally tolerated statin therapy. Continuation: Diagnosis, has benefited from therapy, and will continue taking with statin (if tolerated)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Ninlaro

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Prescribed in combination with lenalidomide (Revlimid) and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: nitrofurantoin suspension

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Prior Authorization required for ages 9 and older. Must provide a valid medical reason as to why the patient cannot take nitrofurantoin in a solid dosage form.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Nubeqa

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	One year
Other Criteria	

Products Affected: Nucala 100 mg injection

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	• For Asthma diagnosis: Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). • For eosinophilic granulomatosis with polyangiitis (EGPA) confirmation of diagnosis required.
Age Restrictions	For Severe Asthma diagnosis: Member must be 6 years of age or older. For eosinophilic granulomatosis with polyangiitis (EGPA) diagnosis: Member must be 18 years of age or older.
Prescriber Restrictions	Prescribed by, or in consultation with an Allergy Specialist, Immunologist, Pulmonary Specialist or Rheumatologist.
Coverage Duration	One year
Other Criteria	

Products Affected: Nuedexta caps

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation of structural neurological condition as the cause of pseudobulbal affect AND disease severity demonstrated by a score of 13 or greater on the Center for Neurologic Study Lability Scale (CNS-LS).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Neurologist.
Coverage Duration	One year
Other Criteria	Member has tried and failed an SSRI.

Products Affected: octreotide inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Odomzo

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Prescribed for locally advanced basal cell carcinoma a) Patient has either: i) Had recurrence after surgery OR (1) Date of surgery provided ii) Is not a candidate for surgery/radiation (1) Reason why patient is not a candidate provided
Age Restrictions	Patient is 18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Dermatologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Ongentys

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Must be used **in combination with** levodopa/carbidopa for members with diagnosis of Parkinson's disease who experience continued "off" episodes or intolerable adverse effects with one of the following: • Catechol-O-methyltransferase (CONT) inhibitor such as entacapone or • Monoamine oxidate type b (MAO-B) inhibitor such as rasagiline or selegiline
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Opzelura

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	**Atopic dermatitis (mild to moderate):** Documentation that trial of a topical corticosteroid OR a topical calcineurin inhibitor was ineffective, contraindicated, or not tolerated. **Nonsegmental Vitiligo**: Initial therapy (approved for 6 months): • Greater than or equal to 0.5% BSA of face is depigmented OR greater than or equal to 3% BSA on non-facial areas is depigmented. • Affected area is less than or equal to 10% total BSA. • Phototherapy trial was ineffective, contraindicated or not tolerated. • Trial of a medium potency or stronger topical corticosteroid OR a topical calcineurin inhibitor was ineffective, not tolerated, or contraindicated. Continuation therapy (approved for one year): • Prescriber attests to an improvement with therapy.
Age Restrictions	12 years or older
Prescriber Restrictions	**Atopic Dermatitis:** Prescribed by, or in consultation with, a Dermatologist, Allergist, or Immunologist. **Nonsegmental Vitiligo:** Prescribed by, or in consultation with, a Dermatologist
Coverage Duration	**Atopic dermatitis:** One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Orencia click inj and SC inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For moderate to severe RA in adults or Adult Psoriatic Arthritis: intolerance to or failure of therapy with Enbrel OR Humira. For Polyarticular Juvenile Idiopathic Arthritis: intolerance to or failure of therapy with Enbrel.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with Rheumatology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Orgovyx

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of advanced prostate cancer, which requires treatment with ADT (androgen deprivation therapy).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Oriahnn

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Member is premenopausal with diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) and member does not have known osteoporosis. Documented trial of hormonal contraceptive, which was ineffective, contraindicated, or not tolerated.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an OB/GYN or other women's health/reproductive specialist
Coverage Duration	Approved for 12 months with one renewal for a total of 24 months of use
Other Criteria	

Products Affected: Orilissa

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of endometriosis or cyclic pelvic pain suspected to be related to endometriosis and member does not have known osteoporosis. Documented trial of one of the following classes of medications which was ineffective, contraindicated, or not tolerated: non-steroidal anti-inflammatory drug (NSAID) or hormonal contraceptive.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an OB/GYN or other women's health/reproductive specialist
Coverage Duration	150 mg tablet - Approved for 24 months without renewal 200 mg tablet - Approved for 6 months without renewal
Other Criteria	

Products Affected: Orserdu

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation is provided of ESR 1 mutation
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Otezla tablets

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For Psoriatic Arthritis: member is intolerant to or failed therapy with methotrexate (at least 20mg/week) AND Otezla will not be used in combination with biologic therapy. Approve for 1 year. For Plaque Psoriasis, initial therapy (approve for 3 months), member must have one of the following: • Moderate to severe plaque psoriasis (≥ 10% body surface involved and significant functional disability) OR • Debilitating palmoplantar psoriasis And failed a minimum of 15 sessions of phototherapy or phototherapy is contraindicated And failed methotrexate (minimum dose of 15 mg/week) or failed acitretin (eq Soriatane). And supporting chart notes or documentation submitted with this request (documentation required), such as: • Documentation of disease severity and progression • Medication dose, duration, response, adverse reactions or contraindications • Phototherapy type, duration, response, adverse reactions or contraindications And Otezla will not be used in combination with biologic therapy. For Plaque Psoriasis, continuing therapy (approve for 1 year), member has demonstrated a significant improvement in their condition AND documented (written explanation accepted) improvement within the past year submitted with this request (documentation is required for approval). For oral ulcers associated with Behcet's disease: • Diagnosis confirmed by the presence of oral ulcers AND at least two of the following: recurrent genital ulceration, eye lesions, skin lesions, positive pathergy test. • Trial of topical triamcinolone 0.1% oral paste was ineffective, not tolerated, or contraindicated.
Age Restrictions	

Prescriber Restrictions	For Psoriatic Arthritis: prescribed by a Rheumatology Specialist For Plaque Psoriasis: prescribed by a Dermatologist For oral ulcers associated with Behcet's disease: Prescribed by, or in consultation with, a rheumatology specialist.
Coverage Duration	As above
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Phenoxybenzamine cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Piqray

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	• Diagnosis of HR+, HER2- advanced breast cancer • Progression on a prior endocrine therapy • Will be used in combination with fulvestrant (Faslodex) • Documentation of a PIK3CA mutation
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Pomalyst capsules

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Praluent

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD) and member is unable to reach LDL goal AND member has ASCVD defined by one of the following: Acute coronary syndromes (ACS), or History of myocardial infarction (MI), or ongoing angina (stable or unstable), or prior coronary or other arterial revascularization, or prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin AND recent fasting lipid panel (within 3 months) provided AND member meets one of the following: 1) member has failed an 8 week trial of high-intensity statin (atorvastatin ≥ 40 mg) in combination with ezetimibe or 2) member has failed an 8 week trial of high-intensity statin (rosuvastatin ≥ 20 mg) in combination with ezetimibe AND prescriber attests the member was adherent to the high-intensity statin therapy AND member meets one of the following 1) member's LDL level remains ≥ 100 mg/dL while on high-intensity statin therapy or 2) member's LDL level remains ≥ 70 mg/dL while on high intensity statin therapy and the member has diabetes AND documentation of high-intensity statin trial attempt is submitted with this request (including trial dates and LDL levels before and after the trial). Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD) and member is unable to tolerate statins AND member has ASCVD defined by one of the following: Acute coronary syndromes (ACS), or History of myocardial infarction (MI), or ongoing angina (stable or unstable), or prior coronary or other arterial revascularization, or prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin AND recent fasting lipid panel (within 3 months) provided AND member has failed three attempts with statins in combination with ezetimibe, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin) in combination with ezetimibe AND member meets one of the following: 1) member's LDL level remains ≥ 100 mg/dL while on maximally tolerated therapy or 2) member's LDL level remains ≥ 70 mg/dL while on maximally tolerated therapy and the member has diabetes AND documentation of high-intensity statin trial attempt is submitted with this request (including trial dates and LDL levels before and after the trial, and a description of adverse events leading to discontinuation). Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) AND member is unable to meet LDL goal AND member has HeFH defined by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo-B, PCSK9 mutation or 2) untreated LDL-C > 190 mg/dL and tendon xanthomas in a

	member or first/second degree relative or 3) untreated LDL-C > 190 mg/dL and either a first degree relative < 60 years of age or a second degree relative < 50 years of age with premature heart disease or 4) untreated LDL-C > 190 mg/dL and a first or second degree relative with total cholesterol > 290 mg/dL AND recent fasting lipid panel (within 3 months) provided AND member meets one of the following: 1) member has failed an 8 week trial of high-intensity statin (atorvastatin ≥ 40 mg) in combination with ezetimibe or 2) member has failed an 8 week trial of high-intensity statin (rosuvastatin ≥ 20 mg) in combination with ezetimibe AND prescriber attests the member was adherent to the high-intensity statin therapy AND member meets one of the following: 1) member's LDL level remains ≥ 100 mg/dL while on high-intensity statin therapy or 2) member's LDL level remains ≥ 70 mg/dL while on high intensity statin therapy and the member has diabetes AND documentation of high-intensity statin trial attempt is submitted with this request (including trial dates and LDL levels before and after the trial). Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) AND member is unable to tolerate statins AND member has HeFH defined by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo-B, PCSK9 mutation or 2) untreated LDL-C > 190 mg/dL and tendon xanthomas in a member or first/second degree relative or 3) untreated LDL-C > 190 mg/dL and either a first degree relative < 60 years of age or a second degree relative < 50 years of age with premature heart disease or 4) untreated LDL-C > 190 mg/dL and a first or second degree relative with total cholesterol > 290 mg/dL AND recent fasting lipid panel (within 3 months) provided AND member has failed three attempts with statins in combination with ezetimibe, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin) in combination with ezetimibe AND member meets one of the following: member's LDL level remains ≥ 100 mg/dL while on maximally tolerated therapy or 2) member's LDL level remains ≥ 70 mg/dL while on maximally tolerated therapy and the member has diabetes AND documentation of high-intensity statin trial attempt is submitted with this request (including trial dates and LDL levels before and after the trial, and a description of adverse events leading to discontinuation).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, Cardiologist, Lipidologist, or Endocrinologist
Coverage Duration	One year. For Continuing Therapy Requests: Member has demonstrated adherence to therapy via claims data AND member had a reduction in LDL-C on PCSK9 inhibitor therapy
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Promacta tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	• thrombocytopenia in adult and pediatric patients 1 year and older with chronic immune (idiopathic) thrombocytopenia (ITP) who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy. • thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy. • in combination with standard immunosuppressive therapy for the first-line treatment of adult and pediatric patients 2 years and older with severe aplastic anemia. • patients with severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	• PROMACTA is not indicated for the treatment of patients with myelodysplastic syndrome (MDS). • Safety and efficacy have not been established in combination with direct-acting antiviral agents used without interferon for treatment of chronic hepatitis C infection

Products Affected: Pulmozyme inh soln

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Purixan Suspension

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	To be used in combination with a chemotherapy maintenance regimen.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist/Hematologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: pyrimethamine tab (eq Daraprim)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	contraindicated in patients with documented megaloblastic anemia due to folate deficiency
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	As of June 2015, pyrimethamine is no longer available in retail pharmacies in the United States. It is only available through a special pharmacy program Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Qbrelis solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Contraindicated if history of angioedema related to previous treatment with an ACE inhibitor; hereditary or idiopathic angioedema; co-administration with aliskiren (Tekturna) in patients with diabetes.
Required Medical information	Must provide a valid medical reason as to why the patient cannot take lisinopril in a solid dosage form
Age Restrictions	Patient is 6 years of age or older
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Qinlock

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Repatha

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD) and member is unable to reach LDL goal AND member has ASCVD defined by one of the following: Acute coronary syndromes (ACS), or History of myocardial infarction (MI), or ongoing angina (stable or unstable), or prior coronary or other arterial revascularization, or prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin AND recent fasting lipid panel (within 3 months) provided AND member meets one of the following: 1) member has failed an 8 week trial of high-intensity statin (atorvastatin ≥ 40 mg) in combination with ezetimibe or 2) member has failed an 8 week trial of high-intensity statin (rosuvastatin ≥ 20 mg) in combination with ezetimibe AND prescriber attests the member was adherent to the high-intensity statin therapy AND member meets one of the following: 1) member's LDL level remains ≥ 100 mg/dL while on high-intensity statin therapy or 2) member's LDL level remains ≥ 70 mg/dL while on high intensity statin therapy and the member has diabetes AND documentation of high-intensity statin trial attempt is submitted with this request (including trial dates and LDL levels before and after the trial). Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD) and member is unable to tolerate statins AND member has ASCVD defined by one of the following: Acute coronary syndromes (ACS), or History of myocardial infarction (MI), or ongoing angina (stable or unstable), or prior coronary or other arterial revascularization, or prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin AND recent fasting lipid panel (within 3 months) provided AND member has failed three attempts with statins in combination with ezetimibe, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin) in combination with ezetimibe AND member meets one of the following: 1) member's LDL level remains ≥ 100 mg/dL while on maximally tolerated therapy or 2) member's LDL level remains ≥ 70 mg/dL while on maximally tolerated therapy and the member has diabetes AND documentation of high-intensity statin trial attempt is submitted with this request (including trial dates and LDL levels before and after the trial, and a description of adverse events leading to discontinuation). Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) AND member is unable to meet LDL goal AND member has HeFH defined by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo-B, PCSK9 mutation or 2) untreated LDL-C > 190 mg/dL and tendon xanthomas in a

	member or first/second degree relative or 3) untreated LDL-C > 190 mg/dL and either a first degree relative < 60 years of age or a second degree relative < 50 years of age with premature heart disease or 4) untreated LDL-C > 190 mg/dL and a first or second degree relative with total cholesterol > 290 mg/dL AND recent fasting lipid panel (within 3 months) provided AND member meets one of the following: 1) member has failed an 8 week trial of high-intensity statin (atorvastatin ≥ 40 mg) in combination with ezetimibe or 2) member has failed an 8 week trial of high-intensity statin (rosuvastatin ≥ 20 mg) in combination with ezetimibe AND prescriber attests the member was adherent to the high-intensity statin therapy AND member meets one of the following 1) member's LDL level remains ≥ 100 mg/dL while on high-intensity statin therapy or 2) member's LDL level remains ≥ 70 mg/dL while on high-intensity statin therapy and the member has diabetes AND documentation of high-intensity statin trial attempt is submitted with this request (including trial dates and LDL levels before and after the trial). Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH) AND member is unable to tolerate statins AND member has HeFH defined by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo-B, PCSK9 mutation or 2) untreated LDL-C > 190 mg/dL and tendon xanthomas in a member or first/second degree relative or 3) untreated LDL-C > 190 mg/dL and either a first degree relative < 60 years of age or a second degree relative < 50 years of age with premature heart disease or 4) untreated LDL-C > 190 mg/dL and a first or second degree relative with total cholesterol > 290 mg/dL AND recent fasting lipid panel (within 3 months) provided AND member has failed THREE (3) attempts with statins in combination with ezetimibe, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin) in combination with ezetimibe AND member meets one of the following: member's LDL level remains ≥ 100 mg/dL while on maximally tolerated therapy or 2) member's LDL level remains ≥ 70 mg/dL while on maximally tolerated therapy and the member has diabetes AND documentation of high-intensity statin trial attempt is submitted with this request (including trial dates and LDL levels before and after the trial, and a description of adverse events leading to discontinuation). Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) AND prescriber is, or has consulted with, a Familial Hypercholesterolemia Specialist AND member meets one of the following 1) two parents diagnosed with Heterozygous Familial Hypercholesterolemia (HeFH) or 2) genetic confirmation of Low Density Lipoprotein (LDL) receptor mutation AND member must meet two of the following 1) Xanthomas present ≤ 10 years of age, 2) Atherosclerotic disease ≤ 20 years of age (written documentation required), 3) Untreated total cholesterol > 290 mg/dL or LDL-C > 190 mg/dL AND most recent full lipid panel (including Apo-B) and two previous lipid panels are provided AND member will not use Repatha in combination with Juxtapid, Kynamro, or apheresis.

Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, Cardiologist, Lipidologist, or Endocrinologist
Coverage Duration	One year. For Continuing Therapy Requests: Member has demonstrated adherence to therapy via claims data AND member had a reduction in LDL-C on PCSK9 inhibitor therapy
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Restasis

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescriber is an Ophthalmologist, Optometrist or Rheumatologist
Coverage Duration	One year
Other Criteria	None.

Products Affected: Retevmo

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation is provided of RET mutation or RET gene fusion.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an oncologist or endocrinologist
Coverage Duration	One year
Other Criteria	

Products Affected: Reyvow

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Trial of a triptan in combination with an NSAID was ineffective, contraindicated, or not tolerated
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Rezlidhia

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation of the IDH1 mutation Continuation: Member is being monitored, has not experienced disease progression, and is appropriate to continue therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Rezurock tablet

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist, hematologist, or transplant specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Ribapak tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Rinvoq

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For moderate to severe Rheumatoid Arthritis (RA): A trial of Humira or Enbrel was ineffective, contraindicated, or not tolerated. For Psoriatic Arthritis (PsA): A trial of Humira or Enbrel was ineffective, contraindicated, or not tolerated. For moderate to severely active Ulcerative Colitis (UC): Initial (approved for 8 weeks): A trial of Humira was ineffective, contraindicated, or not tolerated. Continuing Therapy (approved for 1 year): documentation of improvement in their condition. For Atopic Dermatitis: Initial (approved for 4 months): Member is 12 years of age or older. Member has a diagnosis of moderate to severe atopic dermatitis. Body surface are of 10% or more or chart documentation of severity in sensitive area AND failure of therapy with one of the following: a medium to high potency topical steroid, a topical calcineurin inhibitor, or an oral immunosuppressant, including a biologic. Continuing Therapy (approved for 1 year): Documentation of positive clinical response. For Ankylosing Spondylitis (AS): A trial of Humira or Enbrel was ineffective, contraindicated, or not tolerated.
Age Restrictions	
Prescriber Restrictions	For Rheumatoid Arthritis, Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with a Rheumatology Specialist. For Atopic Dermatitis: Prescribed by, or in consultation with an Allergist, Immunologist, or Dermatologist. For Ulcerative Colitis: Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Form Rheumatoid Arthritis, Psoriatic Arthritis, or Ankylosing Spondylitis: 1 year For Ulcerative Colitis: Initial: 8 weeks, Continuing Therapy: 1 year. For Atopic Dermatitis: Initial 4 months, Continuing Therapy 1 year.
Other Criteria	

Products Affected: Rozlytrek

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	An FDA-approved diagnosis Documentation of appropriate mutation using an FDA-approved test
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Rubraca

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Rydapt capsules

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Sabril powder pack, vigabatrin powder pack and tab, vigadrone powder pack

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by a Neurologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Sandostatin LAR Inj kit

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: sapropterin powder pack and tablet

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For continuing therapy, the patient must have shown a 20% drop in phenylalanine levels after 2 months of sapropterin treatment.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Medical Geneticist or other practitioner specialized in the treatment of Phenylketonuria (PKU).
Coverage Duration	Initial=3 months, then if criteria is met approved for one year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Serostim injection

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of HIV with documented wasting or cachexia. HIV patients must be maintained on antiretroviral therapy for the duration of SEROSTIM treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Signifor inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Simponi 100mg/ml

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial Therapy (8 weeks): Member has a diagnosis of moderately to severely active Ulcerative Colitis. Trial of Humira was ineffective, contraindicated, or not tolerated. Continuing Therapy (1 year): Member has demonstrated a significant improvement in their condition.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Gastroenterology Specialist.
Coverage Duration	Initial: 8 weeks, Continuing Therapy: 1 year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Skyrizi inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For moderate to severe Plaque Psoriasis (greater than or equal to [≥] 10% body surface involved) AND significant functional disability OR debilitating palmoplantar psoriasis Failed a minimum of 15 sessions of phototherapy or phototherapy is contraindicated AND failed methotrexate (minimum dose of 15mg/week) OR failed acitretin (eq Soriatane). Supporting chart notes or documentation must be submitted with request. For Psoriatic Arthritis: Failure of, or intolerance to methotrexate or sulfasalazine For Crohn's Disease: Failure of, or intolerance to a corticosteroid, azathioprine, methotrexate, or 6-mercaptopurine For continuation of therapy: documentation that member has demonstrated a significant improvement in their condition.
Age Restrictions	
Prescriber Restrictions	For Plaque Psoriasis: Prescribed by, or in consultation with, a Dermatology specialist. For Psoriatic Arthritis: Prescribed by, or in consultation with, a rheumatology specialist. For Crohn's Disease: Prescribed by, or in consultation with, a gastroenterology specialist.
Coverage Duration	Initial Therapy: 3-month approval Continuing Therapy: 1-year approval
Other Criteria	

Products Affected: Skytrofa Injection

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	One of the following applies: A trial of somatropin (Genotropin) of at least 12 months resulted in failure to achieve a growth velocity of at least 2cm/year or experienced intolerance, hypersensitivity, or has a contraindication to somatropin (Genotropin) that is not expected to occur with Skytrofa. Age greater than or equal to 1 year and less than 18 years old Weight must be greater than or equal to 11.5 kg Continuation: Annual growth velocity greater than 2.5 cm/year, expected final adult height has not yet been achieved, and epiphyses remain open
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a pediatric endocrinology specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: sofosbuvir.ledipasvir (Harvoni)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer (within past 3 months) 3) Documentation of cirrhosis status (i.e., with or without cirrhosis) 4) Previous Hepatitis C drug therapy and response
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage duration of 8–24 weeks based on cirrhosis status and previous treatment.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected: sofosbuvir/velpatasvir tab (Epclusa)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	(Coadministration of amiodarone with EPCLUSA is not recommended)
Required Medical information	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer (within past 3 months) 3) Documentation of cirrhosis status (i.e., with or without cirrhosis) 4)Previous Hepatitis C drug therapy and response
Age Restrictions	Member must be 3 years of age or older (or weigh at least 17kg)
Prescriber Restrictions	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	12 weeks
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines

Products Affected: somatropin (Genotropin, Humatrope, Nutropin AQ, Norditropin Flexpro, Omnitrope, Saizen, Zomacton)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Prescription Drugs for and/or treatment of idiopathic short stature are excluded per COC
Required Medical information	The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Somavert inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Endocrinologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: sorafenib tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Sotylize oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For patients age 9 and older, must provide a valid medical reason as to why the patient cannot take sotalol in a solid dosage form
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Sprycel tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indication
Exclusion criteria	
Required Medical information	Diagnosis of • newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase. • adults with chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib (Gleevec). • adults with Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy. • children 1 year of age and older with Ph+ CML in chronic phase • children 1 year of age and older with newly diagnosed Ph+ ALL in combination with chemotherapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or Hematologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Stelara

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	**Psoriatic Arthritis:** member is intolerant to or failed therapy with sulfasalazine or methotrexate. **Moderate to Severe Plaque Psoriasis** (greater than or equal to [≥] 10% body surface involved) AND significant functional disability OR debilitating palmoplantar psoriasis AND failed a minimum of 15 sessions of phototherapy or phototherapy is contraindicated AND failed methotrexate (minimum dose of 15mg/week) OR failed acitretin (Soriatane). Supporting chart notes or documentation of disease severity and progression must be submitted with request. • Initial therapy for Plaque Psoriasis (approved for 3 months) • For continuation of therapy for Plaque Psoriasis: documentation that member has demonstrated a significant improvement in their condition must be submitted. **Moderately to Severely active Crohn's Disease** (CD): member failed therapy with corticosteroids, azathioprine, methotrexate, or 6-mercaptopurine. **Moderate to Severely active Ulcerative Colitis** (UC): • Initial therapy (approved for 8 weeks) member failed therapy with corticosteroids, azathioprine, or 6-mercaptopurine. • For continuation of therapy (1 year), documentation that member has demonstrated a significant improvement in their condition must be submitted
Age Restrictions	
Prescriber Restrictions	Psoriatic Arthritis: Prescribed by a Rheumatology Specialist. Plaque Psoriasis: Prescribed by a Dermatology Specialist. Crohn's Disease or Ulcerative Colitis: Prescribed by a Gastroenterology Specialist.
Coverage Duration	One year, except plaque psoriasis = 3 months
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Stivarga tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Sucraid soln

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Hypersensitivity to yeast, yeast products, glycerin (glycerol), or papain
Required Medical information	Documentation to support the diagnosis of congenital sucrose-isomaltase deficiency has been submitted: • Diagnosis of congenital sucrose-isomaltase deficiency has been confirmed by low sucrose activity on duodenal biopsy and other disaccharidases normal on same duodenal biopsy • If small bowel biopsy is clinically inappropriate, difficult, or inconvenient to perform, the following diagnostic tests are acceptable alternatives (all must be performed and results submitted): 1. Stool pH less than 6; AND 2. Breath hydrogen increase greater than 10 ppm following fasting sucrose challenge; AND 3. Negative lactose breath test
Age Restrictions	
Prescriber Restrictions	Prescribed by a gastroenterologist, endocrinologist, or genetic specialist
Coverage Duration	One year
Other Criteria	Member does not have secondary (acquired) disaccharidase deficiencies

Products Affected: sunitinib (eq Sutent) cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Sunosi

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	**Excessive daytime sleepiness with narcolepsy:** • Initial criteria – Documentation of a full nocturnal polysomnogram and a multiple sleep patency test showing mean onset to sleep of less than 8 minutes and two or more sleep onset REM sleep periods provided – Trial of one of the following was ineffective, contraindicated, or not tolerated: armodafinil or modafinil • Continuation criteria – Documentation of reduction in symptoms of excessive daytime sleepiness **Excessive daytime sleepiness due to obstructive sleep apnea:** • Initial criteria – Excessive daytime sleepiness persists despite continuous compliant use of positive airway pressure therapy at least one month – Trial of one of the following was ineffective, contraindicated, or not tolerated: armodafinil or modafinil • Continuation criteria – Documentation of reduction in symptoms of excessive daytime sleepiness – Continued to be used in conjunction with positive airway pressure therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or board-certified sleep medicine specialist
Coverage Duration	3 months for initial; 1 year for continuation
Other Criteria	

Products Affected: Supprelin LA Kit

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Symdeko, Kalydeco tab and packet

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	**Initial Coverage:** • Prescribed by a pulmonologist at a Cystic Fibrosis Center of Excellence • Homozygous for the F508del CFTR mutation or has at least one mutation in the CFTR gene that is responsive based on in vitro data/clinical evidence; documented by an FDA-cleared Cystic Fibrosis mutation test followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. **Continuation Coverage:** Prescriber attests that patient has been adherent to therapy.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Synarel Nasal Solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Tabrecta

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation is provided of MET exon 14 skipping mutation.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an oncologist.
Coverage Duration	One year
Other Criteria	

Products Affected: tadalafil 20mg (eq Adcirca) and sildenafil 20mg (eq Revatio) (PAH)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Patient requires nitrate therapy on a regular or intermittent basis Concurrent use of guanylate cyclase stimulators (e.g., Adempas).
Required Medical information	Diagnosis of pulmonary arterial hypertension (WHO Group I) confirmed by right heart catheterization and NYHA Functional Class II or III symptoms.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Tafinlar cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	➢ Confirm the presence of BRAF V600E mutation in tumor specimens prior to initiation of treatment with TAFINLAR as a single agent. ➢ Confirm, in combination with trametinib (Mekinist), for: o the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test. o the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test, and involvement of lymph node(s), following complete resection. o the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test. o the treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options. o The treatment of solid tumor(unresectable or metastatic) in combination with trametinib (Mekinist) with BRAF V600E mutation, as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	One year
Other Criteria	TAFINLAR is not indicated for treatment of patients with wild-type BRAF melanoma, wild-type BRAF NSCLC, or wild-type BRAF

Products Affected: Taltz

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	**Psoriatic Arthritis and Peripheral Spondylarthritis**: member intolerant to or failed therapy with sulfasalazine or methotrexate. (not required for diagnosis of Ankylosing Spondylitis with Predominant Axial involvement). **Moderate to Severe Plaque Psoriasis** (greater than or equal to [≥] 10% body surface involved) AND significant functional disability OR debilitating palmoplantar psoriasis: failed a minimum of 15 sessions of phototherapy or phototherapy is contraindicated AND failed methotrexate (minimum dose of 15mg/week) OR failed acitretin capsules (Soriatane equiv). Supporting chart notes or documentation must be submitted with request. **For continuation of therapy for Plaque Psoriasis**: documentation that member has demonstrated a significant improvement in their condition.
Age Restrictions	
Prescriber Restrictions	Psoriatic Arthritis, Peripheral Spondylarthritis and Ankylosing Spondylitis with Predominant Axial involvement: Prescribed by a Rheumatology Specialist. Plaque Psoriasis: Prescribed by a Dermatologist.
Coverage Duration	One year
Other Criteria	

Products Affected: Talzenna capsules

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of germline BRCA-mutated, HER2-negative locally advanced or metastatic breast cancer Documentation of deleterious or suspected deleterious germline BRCA mutation confirmed by FDA-approved test
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Tasigna cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Do not use in patients with hypokalemia, hypomagnesemia, or long QT syndrome.
Required Medical information	• Adult and pediatric patients greater than or equal to 1 year of age with newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase. • Adult patients with chronic phase (CP) and accelerated phase (AP) Ph+ CML resistant to or intolerant to prior therapy that included imatinib. • Pediatric patients greater than or equal to 1 year of age with Ph+ CML-CP resistant or intolerant to prior tyrosine-kinase inhibitor (TKI) therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Tegsedi inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR) **Amyloidosis** confirmed by positive tissue biopsy or laser capture tandem mass spectrometry AND **hATTR** confirmed by genetic sequencing **Polyneuropathy** confirmed by one of the following: • Baseline Polyneuropathy Disability (PND) score of ≥ 1 • Baseline Familial Amyloidosis Polyneuropathy (FAP) Stage of ≥ 1 with at least one of the following: o Autonomic dysfunction o Symmetrical length-dependent peripheral neuropathy beginning in lower limbs, progresses proximally involving areas above the ankles, legs, thighs, arms and anterior trunk. o Bilateral carpal tunnel syndrome o Cardiac symptoms
Age Restrictions	≥ age 18 years of age
Prescriber Restrictions	Prescribed by a neurologist, cardiologist, hematologist or other specialist experienced in the diagnosis and treatment of hATTR
Coverage Duration	One year
Other Criteria	Not used in combination with Vynaqel, Vyndamax or Onpattro

Products Affected: temozolomide cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: temsirolimus IV inj, Torisel soln

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	temsirolimus is contraindicated in patients with bilirubin > 1.5 x ULN
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Tepmetko Tablet

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation of METex14 skipping mutation
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: testosterone cypionate injection

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of hypogonadism (primary or hypogonadotropic) AND diagnosis has been confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference value.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: testosterone gel packet 1.62% 1.25gm (androgel equiv), testosterone gel packet 1.62% 2.5gm (Androgel equiv), testosterone solution (Axiron equiv)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of hypogonadism (primary or hypogonadotropic) AND diagnosis has been confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference range
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: tetrabenazine (Xenazine) tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of chorea due to Huntington's Disease.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Neurologist or in consultation with a Neurologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Thalomid cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist or Infectious Disease Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Tibsovo

PA criteria	**Criteria Details**
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation of IDH1 mutation by an FDA-approved test **must** be submitted with the request.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	One year
Other Criteria	

Products Affected: tiopronin tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	• Prescribed for the treatment of severe homozygous cystinuria, in a member who is not responsive to high fluid intake, alkali, and diet modification alone
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Nephrologist or Urologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Tirosint oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For patients age 9 and older, must provide a valid medical reason as to why the patient cannot take levothyroxine in a solid dosage form.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Tobi podhaler

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of cystic fibrosis, with *Pseudomonas aeruginosa* colonization and a trial of tobramycin nebulized solution was ineffective, contraindicated, or not tolerated.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Infectious Disease Specialist or Pulmonology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: tobramycin nebulizer solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: tolvaptan tabs, Samsca

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	**Contraindications:** • Need to raise serum sodium acutely • Patients who are unable to respond appropriately to thirst • Hypovolemic hyponatremia • Concomitant use of strong CYP 3A inhibitors • Anuria
Required Medical information	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (e.g., nausea, vomiting, headache, lethargy, confusion).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or a nephrologist.
Coverage Duration	30 days only
Other Criteria	SAMSCA should be initiated and re-initiated in a hospital. Do not administer SAMSCA for more than 30 days to minimize the risk of liver injury

Products Affected: Tremfya

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of moderate-to-severe **Plaque Psoriasis**: For Initial Therapy, trial of Taltz, Enbrel, Humira, Otezla, Skyrizi or Stelara was ineffective, contraindicated or not tolerated. Continuing Therapy: documentation of significant improvement within the past year is received. Diagnosis of **Psoriatic Arthritis**: trial of Taltz, Enbrel, Humira, Otezla, Skyrizi, or Stelara was ineffective, contraindicated or not tolerated.
Age Restrictions	
Prescriber Restrictions	Plaque Psoriasis: prescribed by a Dermatologist Psoriatic Arthritis: prescribed by a Rheumatology Specialist
Coverage Duration	Plaque Psoriasis: Initial = 3 months, continuing therapy = 1 year Psoriatic Arthritis: 1 year
Other Criteria	

Products Affected: tretinoin capsules (Vesanoid equiv)

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Retinoids: tretinoin cream or gel

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of acne vulgaris
Age Restrictions	Members age 35 or older require prior authorization
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: trientine (Syprine) cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Treatment of patients with Wilson disease who are intolerant of penicillamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Trintellix

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation was submitted (consistent with pharmacy claims data, OR for new members, consistent with medical chart history) adequate trial (including dates and doses) of a generic selective serotonin reuptake inhibitor (SSRI) and/or has another documented medical reason (intolerance, hypersensitivity, etc.) for not taking an SSRI.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Trulance

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of one of the following: • Chronic idiopathic constipation (CIC) • Irritable bowel syndrome with constipation (IBS-C) A trial of one of the following was ineffective, contraindicated, or not tolerated: • Stimulants (bisacodyl, sennosides) or • PEG 3350 (Miralax, Glycolax) • Bulk-forming laxatives (Metamucil, Citrucel, Fibercon)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Truseltiq

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Initial approval: Documentation of an FGFR2 fusion or rearrangement, trial of at least 1 prior line of systemic therapy, and has progressed on a previous FGFR2 inhibitor Continuation: Is being monitored, has not experienced progression, and is appropriate to continue therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Truvada

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For pre-exposure prophylaxis of HIV infection: Documentation that the generic product emtricitabine/tenofovir disoproxil fumarate (TRUVADA equivalent) was previously tried and caused an adverse event
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Tukysa

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Turalio

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT, also known as PVNS or GCT-TS) associated with severe morbidity or functional limitations and not amenable to improvement with surgery. Patient is not candidate for surgical resection as determined by orthopedic or hand surgeon
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Tymlos inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Postmenopausal woman with osteoporosis and history of an osteoporotic low trauma fracture or BMD screening results -2.5 or below, AND inadequate response, intolerance or contraindication to oral or injectable bisphosphonate. Documented recent calcium and Vitamin D levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: One year Continuation: 6 months
Other Criteria	Treatment duration: Use of TYMLOS for more than 18 months during a patient's lifetime is not recommended. Cumulative use of TYMLOS and parathyroid hormone analogs (e.g., Forteo) for more than 2 years during a patient's lifetime is not recommended.

Products Affected: Tyvaso inh solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of pulmonary arterial hypertension (World Health Organization group 1) confirmed by right heart catheterization with NYHA Class III symptoms or pulmonary hypertension associated with interstitial lung disease (WHO group 3) to improve exercise ability with confirmed by right heart catheterization and High Resolution Computed Tomography (HRCT).
Age Restrictions	
Prescriber Restrictions	Restricted to or on consult with Pulmonology or Cardiology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Ubrelvy

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Trial of a triptan was ineffective or not tolerated
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Uceris Rectal Foam, budesonide rectal foam

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Patient has active mild to moderate distal ulcerative colitis and has tried and failed or was intolerant to mesalamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Uptravi

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Patient has Pulmonary Arterial Hypertension (PAH) **(ICD 10 Code: I27.0)**, WHO Group I, diagnosed by right heart catheterization
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Cardiologist or Pulmonologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Valchlor gel

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Prescribed for the topical treatment of stage IA or IB mycosis fungoides–type cutaneous T-cell lymphoma AND Patient has received at least TWO (2) prior skin-directed therapies including: topical steroids AND phototherapy (UVB or PUVA).
Age Restrictions	
Prescriber Restrictions	Prescribed by Oncology or Dermatology Specialist or in consultation with an Oncology or Dermatology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: valganciclovir 450mg tab and 50mg/ml solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Vantas Kit

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Varubi tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by Oncology or Hematology Specialist
Coverage Duration	One year
Other Criteria	

Products Affected: Veltassa

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Hyperkalemia (> 5.3 mmol/L) persists despite both of the following: • Dietary management AND • Use of diuretics (if appropriate) Patient meets one of the following: • Has tried and failed or was intolerant to sodium zirconium cyclosilicate (Lokelma) **OR** • Has a condition (i.e. chronic kidney disease or heart failure) for which sodium zirconium cyclosilicate (Lokelma) would be inappropriate
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist, cardiologist, or endocrinologist
Coverage Duration	One year
Other Criteria	

Products Affected: Ventavis Inh Soln

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of pulmonary arterial hypertension (World Health Organization group 1) confirmed by right heart catheterization with NYHA Class III-IV symptoms.
Age Restrictions	
Prescriber Restrictions	Restricted to or on consult with Pulmonology or Cardiology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Verzenio tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Vijoice

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation is provided of mutation in the PIK3CA gene. For continuation requests: Prescriber attests to improvement in the member's condition with use of this medication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Vitrakvi

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	• Diagnosis of solid tumor • Documentation the tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation • Tumor is metastatic or where surgical resection is likely to result in severe morbidity (unresectable) • Patient has no satisfactory alternative treatments or has progressed following treatment
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Vizimpro tablets

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of metastatic NSCLC with EGFR exon 19 deletion or exon 21 L858R substitution mutations Documentation of the presence of the mutation as detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an oncologist
Coverage Duration	One year
Other Criteria	

Products Affected: Vonjo

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	A trial of ruxolitinib (Jakafi) was ineffective, contraindicated, or not tolerated.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: voriconazole tab and suspension

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Infectious Disease Specialist or Oncologist or in consultation with an Infectious Disease Specialist or Oncologist
Coverage Duration	6 months
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Vosevi tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Required Medical Info: 1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments
Age Restrictions	Patient must be 18 years of age or older.
Prescriber Restrictions	Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.
Coverage Duration	Coverage duration of 12 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	

Products Affected: Votrient tab, pazopanib tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Vyndamax

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	A) Diagnosis of ATTR-CM confirmed by one of the following: i) cardiac biopsy with positive Congo Red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining or ii) Myocardial uptake of Tc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence B) Absence of light-chain or other forms of amyloidosis confirmed by all three of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 and ii) Absence of monoclonal protein via serum protein immunofixation and iii) Absence of monoclonal protein via urine protein immunofixation.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restrictions	Prescribed by, or in consultation with, a Cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.
Coverage Duration	One year. Continuation: Attestation of a positive clinical response; will not be used with Onpattro or Tegsedi.
Other Criteria	Will not be used concomitantly with Onpattro (patisiran) or Tegsedi (inotersen)

Products Affected: Vyndaqel

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	A) Diagnosis of ATTR-CM confirmed by one of the following: i) cardiac biopsy with positive Congo Red staining and ATTR confirmation by mass spectrometry or immunofluorescence staining or ii) Myocardial uptake of Tc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence B) Absence of light-chain or other forms of amyloidosis confirmed by all three of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 and ii) Absence of monoclonal protein via serum protein immunofixation and iii) Absence of monoclonal protein via urine protein immunofixation.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restrictions	Prescribed by, or in consultation with, a Cardiologist or other provider experienced in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis.
Coverage Duration	One year. Continuation: Attestation of a positive clinical response; will not be used with Onpattro or Tegsedi.
Other Criteria	Will not be used concomitantly with Onpattro (patisiran) or Tegsedi (inotersen)

Products Affected: Vyzulta, Zioptan, tafluprost

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Documentation of failure, intolerance, or contraindication to latanoprost, bimatoprost 0.03% (Lumigan equiv), travoprost (Travatan Z equiv), or Lumigan 0.01%
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Xalkori cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Xatmep oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For patients age 9 and older, must provide a valid medical reason as to why the patient cannot take methotrexate in a solid dosage form
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Xatmep oral solution, Jylamvo oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For patients age 9 and older, must provide a valid medical reason as to why the patient cannot take methotrexate in a solid dosage form
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	

Products Affected: Xeljanz tab, Xeljanz XR tab, Xeljanz oral solution

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For moderate to severe Rheumatoid Arthritis (RA): A trial of Humira or Enbrel was ineffective, contraindicated, or not tolerated. For Polyarticular Juvenile Idiopathic Arthritis (PJIA): A trial of Humira or Enbrel was ineffective, contraindicated, or not tolerated. For Psoriatic Arthritis (PsA): A trial of Humira or Enbrel was ineffective, contraindicated, or not tolerated. For Ulcerative Colitis (UC): Initial (approved for 8 weeks): A trial of Humira was ineffective, contraindicated, or not tolerated. Continuing Therapy (approved for 1 year): Member has demonstrated a significant improvement in their condition. For Ankylosing Spondylitis (AS): A trial of Humira or Enbrel was ineffective, contraindicated, or not tolerated.
Age Restrictions	
Prescriber Restrictions	For Rheumatoid Arthritis, PJIA or Psoriatic Arthritis: Prescribed by, or in consultation with a Rheumatology Specialist. For Ulcerative Colitis: Prescribed by, or in consultation with a Gastroenterology Specialist.
Coverage Duration	Initial approval for Ulcerative Colitis: 8 weeks. Continuing therapy: 1 year All others: One year
Other Criteria	Continuing Therapy: documentation of significant improvement of their condition.

Products Affected: Xembify

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of primary immunodeficiency such as: agammaglobulinemia due to absence of B cells, hypogammaglobulinemia, normal immunoglobulins with poor antibody function or a genetically defined primary immunodeficiency disease and one of the following: • Inadequate responsiveness to specific antigens (ex: pneumococcal polysaccharide) • History of recurrent significant infection
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, allergist or immunologist
Coverage Duration	One year
Other Criteria	

Products Affected: Xolair inj

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's IgE level must be between 30 IU/ml and 700 IU/ml (OR between 30 IU/mL and 1300 IU/mL for members aged 6 to 12 years) , AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contraindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment. 3. If for Nasal polyps: documentation of confirmed diagnosis and inadequate response to nasal corticosteroids Continuation criteria: documentation is provided of positive clinical response.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old. If for nasal polyps, patient must be at least 18 years old.
Prescriber Restrictions	Prescribed by, or in consultation with, an Allergy Specialist, Pulmonary Specialist, Dermatologist, ENT Specialist, or Immunologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Xospata

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of relapsed/refractory acute myeloid leukemia (AML) Documentation of FLT3 mutation by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or Hematologist
Coverage Duration	One year
Other Criteria	

Products Affected: Xyrem, Sodium Oxybate

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	**Initial Therapy** - ***Excessive Daytime Sleepiness*** with Narcolepsy (3 Month Approval) • Diagnosis of Excessive Daytime Sleepiness with Narcolepsy • Documentation of a full nocturnal polysomnogram and a multiple sleep patency test showing mean onset to sleep of less than 8 minutes and two or more sleep onset REM sleep periods provided • Patient has tried and failed armodafinil or modafinil **Initial Therapy** - ***Cataplexy*** with Narcolepsy (3 Month Approval) • Diagnosis of Cataplexy with Narcolepsy • Documentation of the frequency or severity of cataplexy attacks provided. • Documentation of either: ❖ a full nocturnal polysomnogram and a multiple sleep patency test showing mean onset to sleep of less than 8 minutes and two or more sleep onset REM sleep periods provided ❖ Low cerebrospinal fluid orexin-A concentration. **Continuing Therapy** - 1 Year Approval (**ALL** criteria must be met) • Chart documentation of reduction in cataplexy attacks or symptoms of excessive daytime sleepiness submitted
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with a neurologist or board-certified sleep medicine specialist
Coverage Duration	Initial Therapy: 3 months; Continuing Therapy: 1 year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Zejula

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Zelboraf tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test. Diagnosis of Erdheim-Chester Disease with BRAF V600 mutation.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	One year
Other Criteria	ZELBORAF is not indicated for treatment of patients with wild-type BRAF melanoma.

Products Affected: Zeposia 0.92mg cap, Zeposisa Starter Kit Pack

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	For Ulcerative Colitis: Intolerance to, or failure of, therapy with one of the following: a.) Humira, b) Stelara, c) Rinvoq OR d) Xeljanz
Age Restrictions	
Prescriber Restrictions	For Multiple Sclerosis: Prescribed by, or in consultation with, a neurology specialist. For Ulcerative Colitis: Prescribed by, or in consultation with, a gastroenterology specialist
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Zoladex implant

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Zolinza cap

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent or recurrent disease on or following two systemic therapies.
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology or Hematology Specialist or in consultation with an Oncology or Hematology Specialist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Zontivity tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	Contraindications: • History of stroke, transient ischemic attack or intracranial hemorrhage • Active pathologic bleeding (e.g., intracranial bleeding, peptic ulcer bleeding)
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by a Cardiology Specialist or in consultation with a Cardiology Specialist.
Coverage Duration	One year
Other Criteria	Use with aspirin and/or clopidogrel according to their indications or standard of care. There is limited clinical experience with other antiplatelet drugs and none with ZONTIVITY as the only antiplatelet agent

Products Affected: Zorbtive

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Member has a diagnosis of short bowel syndrome (SBS). Member is unable to ingest solid food. Member is dependent on parenteral nutrition at least 5 days per week to provide at least 3,000 calories per week.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

Products Affected: Zydelig tab

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or Hematologist
Coverage Duration	One year
Other Criteria	Zydelig is not indicated and is not recommended for first-line treatment of any patient

Products Affected: Zykadia

PA criteria	Criteria Details
Covered uses	All FDA-approved indications
Exclusion criteria	
Required Medical information	Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncologist.
Coverage Duration	One year
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.