Prior Authorization Detail
May 2022

GENERAL DISCLAIMER:

Bright Health does not recognize the use of drug samples to meet clinical criteria requirements for prior drug use for drugs covered under the pharmacy benefit or drugs administered in the physician office or other outpatient setting. A physician's statement that samples have been used cannot be used as documentation of prior drug use.

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 year of age or older for monotherapy
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has not experienced disease progression following prior CDK inhibitor therapy

ABIRATERONE

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	One of the following: (1) Previous bilateral orchiectomy, (2) Castrate level of testosterone (i.e., less than 50 ng/dL), or (3) Concurrent use with a gonadotropin-releasing hormone (GnRH) analog (e.g., leuprolide, goserelin, histrelin, degarelix) Yonsa only: Trial of or contraindication to Zytiga (abiraterone acetate)

ABOBOTULINUMTOXINA

Products Affected

- DYSPORT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	CERVICAL DYSTONIA OR SPASMODIC TORTICOLLIS, LOWER OR UPPER LIMB SPASTICITY: No contraindications including (1) pregnancy OR (2) sensitivity or allergic reaction to other botulinum toxins OR (3) allergy to cows milk protein OR (4) Not being used for treatment of moderate to severe glabellar lines
Required Medical Information	None
Age Restrictions	Cervical dystonia, Spasmodic torticollis: 18 years of age or older. Lower or upper limb spasticity: 2 years of age or older
Prescriber Restrictions	None
Coverage Duration	6 months. IL: 12 months
Other Criteria	A. CERVICAL DYSTONIA OR SPASMODIC TORTICOLLIS: The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patients medical records. B. LOWER OR UPPER LIMB SPASTICITY: Patient does not have spasticity caused by cerebral palsy. CAUTION (1) Potency of units between different preparations of botulinum toxin products is not interchangeable AND (2) Spread of toxin effects may cause swallowing and breathing difficulties AND (3) Re-treatment should not occur in intervals of less than 12 weeks

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Pregnancy Patients with severely impaired liver or kidney function and in patients with chronic abnormally elevated blood lipid values. Hypersensitivity to other retinoids. Concurrent use with methotrexate, tetracyclines.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist
Coverage Duration	INITIAL: 3 months. RENEWAL: 1 year. IL: 12 months
Other Criteria	INITIAL: Patient has a documented diagnosis of severe psoriasis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to a minimum 90-day trial of high dose topical steroid (i.e. betamethasone augmented, halobetasol); AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to, 90-day trial of Methotrexate. RENEWAL: Prescriber attests to a positive therapeutic response to therapy. Quantity Limit: Maximum of 2 capsules per day

ACYCLOVIR OINTMENT

Products Affected

- *acyclovir topical ointment*

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	GENITAL HERPES: Patient has diagnosis of Genital Herpes caused by the herpes simplex virus; AND Patient has had a trial and failure, intolerance, or contraindication to TWO of the following: oral acyclovir, valacyclovir, or famciclovir.

ADALIMUMAB

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	UVEITIS: Isolated anterior uveitis
Required Medical Information	None
Age Restrictions	RHEUMATOID ARTHRITIS (RA), PSORIATIC ARTHRITIS (PsA), ANKYLOSING SPONDYLITIS (AS), PSORIASIS (PsO): 18 years of age or older POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), UVEITIS: 2 years of age or older CROHNS DISEASE (CD): 6 years of age or older ULCERATIVE COLITIS: 5 years of age or older HIDRADENITIS SUPPURATIVA (HS): 12 years of age or older
Prescriber Restrictions	RA/PJIA/AS: Prescribed by or given in consultation with a rheumatologist. PsA: Prescribed by or given in consultation with a rheumatologist or dermatologist. PsO: Prescribed by or given in consultation with a dermatologist. CD/UC: Prescribed by or given in consultation with a gastroenterologist. UVEITIS: Prescribed by or in consultation with an ophthalmologist
Coverage Duration	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: Trial of or contraindication to at least 3 months of treatment with ONE DMARD (disease-modifying antirheumatic drugs), such as methotrexate dose greater than or equal to 20mg per week or maximally tolerated dose, leflunomide, hydroxychloroquine, or sulfasalazine. PJIA: (1) Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. (2) Documentation of patients current weight. PsA: Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. AS: Patient had a previous trial of or contraindication to an NSAID. PsO: (1) Psoriatic lesions involving greater than or equal to 3% or more of body surface area (BSA) or psoriatic lesions affecting the hands, feet, genital area, or face. (2) Trial of or contraindication to one or more forms of conventional therapies such as PUVA (phototherapy ultraviolet light A), UVB (ultraviolet light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. CD/UC: Trial of or contraindication to one conventional agent such as corticosteroids (i.e., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. UVEITIS: Documentation of patients current weight if between 2 to 17 years of age. RENEWAL:

PA Criteria	Criteria Details
	RA: (1) Patient experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. (2) If request is for Humira 40mg dosed every week OR Humira 80mg dosed every other week, patient had a trial of at least a 3-month regimen of Humira 40mg dosed every other week. PJIA/PsA: Patient experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy AS: Patient experienced or maintained an improvement of at least 50% or 2 units (scale of 1-10) in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) while on therapy. PsO: Patient achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more while on therapy. UVEITIS: Patient has not experienced treatment failure, defined as ONE of the following: (1) Development of new inflammatory chorioretinal or retinal vascular lesions, (2) A 2-step increase from baseline in anterior chamber cell grade or vitreous haze grade, (3) A worsening of best-corrected visual acuity (BCVA) by at least 15 letters relative to best state achieved.

ADEFOVIR

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease physician, gastroenterologist, hepatologist, or transplant physician
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of chronic hepatitis B; AND Patient has evidence of active viral replication; AND Patient has elevated ALT or AST or histologically active disease; AND Patient has had a trial and failure, intolerance, or contraindication to therapy with generic entecavir.

ANABOLIC STEROIDS

Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications. Anadrol-50: Fanconis anemia, cachexia associated with AIDS. Oxandrin: Cachexia associated with AIDS, Turners syndrome
Exclusion Criteria	INITIAL: Contraindication to anabolic steroid therapy: a) Known or suspected carcinoma of the prostate or breast in male patients b) Known or suspected carcinoma of the breast in females with hypercalcemia c) Known or suspected nephrosis (the nephrotic phase of nephritis) d) Known or suspected hypercalcemia e) Severe hepatic dysfunction
Required Medical Information	INITIAL: CACHEXIA ASSOCIATED WITH AIDS: 1) Patient has a documented viral load (with date) of less than 200 copies per mL within the past 3 months. 2) Patient meets one of the following: a) 10% unintentional weight loss over 12 months b) 7.5% unintentional weight loss over 6 months c) 5% body cell mass (BCM) loss within 6 months d) Body cell mass (BCM) of less than 35% (men) and a body mass index (BMI) of less than 27 kg per meter squared e) Body cell mass (BCM) of less than 23% (women) of total body weight and a body mass index (BMI) of less than 27 kg per meter squared f) BMI of less than 18.5 kg per meter squared. RENEWAL: 1) Patient has a documented viral load (with date) of less than 200 copies per mL within the past 3 months 2) Patient has responded to therapy as measured by at least a 10% increase in weight from baseline (current weight must have been measured within the last 4 weeks, document date of measurement)
Age Restrictions	None

PA Criteria	Criteria Details
Prescriber Restrictions	CACHEXIA ASSOCIATED WITH AIDS: Prescribed by or in consultation with a gastroenterologist, nutritional Support Specialist (SBS) or Infectious Disease specialist
Coverage Duration	ANM: 6 mo and IL: 12 mo For PROT CTB, BONE PAIN OP, TRNRS: 6 mo CCHX AIDS, WT GN: 12 wk.
Other Criteria	INITIAL: ANEMIA: 1) Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes, 2) The request is for Anadrol-50. CACHEXIA ASSOCIATED WITH AIDS:1) Patient is on anti-retroviral therapy, 2) Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes ADJUNCTIVE THERAPY FOR WEIGHT GAIN, ADJUNCTIVE THERAPY TO OFFSET PROTEIN CATABOLISM, BONE PAIN ACCOMPANYING OSTEOPOROSIS, TURNERS SYNDROME: 1) Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes, 2) The request is for Oxandrin RENEWAL: CACHEXIA ASSOCIATED WITH AIDS: 1) Patient is on anti-retroviral therapy 2) Patient has not received more than 24 weeks of therapy in a calendar year

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	PSORIATIC ARTHRITIS (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist PLAQUE PSORIASIS (PsO): Prescribed by or in consultation with a dermatologist. ORAL ULCERS ASSOCIATED WITH BEHCETS DISEASE: Prescribed by or in consultation with a rheumatologist
Coverage Duration	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: PsA: Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. Mild PsO: (1) Trial or contraindication to one conventional systemic agent (e.g., methotrexate, calcipotriene, acitretin, cyclosporine) AND one conventional topical agent (e.g., PUVA, UVB, topical corticosteroids).(2) One of the following: Psoriasis covering 2% of body surface area (BSA), Static Physician Global Assessment (sPGA) score of 2, OR Psoriasis Area and Severity Index (PASI) score of 2 to 9. Moderate to Severe PsO: (1) Psoriasis covering 3% or more of body surface area or psoriatic lesions affecting the hands, feet, genital area, or face. (2) Trial of or contraindication to one or more forms of conventional therapies such as a PUVA (phototherapy ultraviolet light A), UVB (ultraviolet light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. ORAL ULCERS ASSOCIATED WITH BEHCETS DISEASE: Trial of or contraindication to ONE or more conservative treatments (e.g., colchicine, topical corticosteroid, oral corticosteroid, etc.). RENEWAL: PsA: Patient experienced or maintained a 20% or greater improvement in tender or swollen joint count while on therapy. Mild PsO: Patient achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more OR a decrease in sPGA (static Physician Global Assessment) by at least a 2-point reduction from baseline. Moderate PsO: Patient achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more. ORAL ULCERS ASSOCIATED WITH BEHCETS DISEASE: Patient achieved or maintained clinical benefit compared to baseline (e.g., pain scores, number of ulcers, etc.).

ARIPIPRAZOLE

Products Affected

- ABILIFY MAINTENA
- *aripiprazole oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	History of a hypersensitivity reaction to aripiprazole.
Required Medical Information	Medication usage (trial and failure, intolerance, contraindication) must be supported by documentation from the patient's chart notes/medical records/electronic claim history.
Age Restrictions	SCHIZOPHRENIA: (1) aripiprazole oral solution:13 years of age and older, (2) Abilify Maintena:18 years of age and older. ACUTE BIPOLAR MANIA (aripiprazole oral solution):10 years of age and older. BIPOLAR I DISORDER MAINTENANCE MONOTHERAPY (Abilify maintena): 18 years of age or older. MDD: 18 years of age and older. AUTISTIC DISORDER: 6 years of age and older.
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	A. SCHIZOPHRENIA: (1) Patient has a diagnosis of Schizophrenia, AND (2) Patient has had a trial and failure, intolerance, or contraindication of the formulary alternative, risperidone, AND (3) Patient has had a trial and failure, intolerance or contraindication of the formulary alternative, aripiprazole tablet. B. ACUTE BIPOLAR MANIA: (1) Patient has a diagnosis of Acute bipolar mania, including manic and mixed episodes associated with bipolar disorder, AND (2) Patient has had a trial and failure, intolerance or contraindication of the formulary alternative, risperidone, AND (3) Tried and failed, intolerance or contraindication of the formulary alternative, aripiprazole tablet. C. MAJOR DEPRESSIVE DISORDER: (1) Patient has a diagnosis of Major Depressive Disorder, AND (2) Patient has had a trial and failure, intolerance or contraindication of the formulary alternatives, fluoxetine, paroxetine, sertraline, citalopram, venlafaxine and bupropion (medication usage must be supported by documentation from the patients chart notes/medical records/electronic claim history), AND (3) Patient has had a trial and failure, intolerance or contraindication of the formulary alternatives, escitalopram and desvenlafaxine (Pristiq) (medication usage must be supported by documentation from the patients chart notes/medical records/electronic claim history), AND (4) Patient has had a trial and failure, intolerance or contraindication of the formulary alternative, risperidone, AND (5) Patient has had a trial and failure, intolerance or contraindication of the formulary alternative, aripiprazole tablet, AND (6) Requested medication must be used as adjunctive or add-on treatment to ADT and not as monotherapy. D. AUTISTIC DISORDER (1) Patient has a diagnosis of autistic disorder, AND (2) Patient has had a trial and failure, intolerance or contraindication of the formulary alternative, risperidone, AND (3) Patient has had a trial and failure, intolerance or contraindication of the formulary alternative, aripiprazole tablet, AND (4) Patient has had a trial and failure, intolerance, or contraindication to formulary stimulant medications, methylphenidate, dextroamphetamine,
	amphetamine/dextroamphetamine (medication usage must be supported by documentation from the patients chart notes/medical records/electronic claim history).

ARMODAFINIL

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	Treatment for the underlying obstruction in OSA. Patients with known hypersensitivity to modafinil.
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep specialist.
Coverage Duration	12 months
Other Criteria	NARCOLEPSY: Patient has a diagnosis of narcolepsy supported by a sleep study [documentation required]; AND Documentation has been provided to confirm diagnosis of narcolepsy is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or another general medical condition; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least one formulary/preferred treatment, such as methylphenidate or dextroamphetamine. SHIFT WORK SLEEP DISORDER: Patient is experiencing excessive sleepiness and working a minimum of five (or more) overnight shifts per month [Documentation of current work schedule is required]; AND Documentation has been provided to confirm diagnosis is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication). OBSTRUCTIVE SLEEP APNEA: Patient has a diagnosis of obstructive sleep apnea is supported by a sleep study [documentation required]; AND Patient has been on CPAP for at least 2 months and is using it on average greater than or equal to 4 hours per night.

ASENAPINE

Products Affected

- *asenapine maleate*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	Known hypersensitivity to asenapine
Required Medical Information	None
Age Restrictions	Bipolar I disorder, Monotherapy - 10 years of age and older All other indications : 18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	(1) Patient has diagnosis of bipolar disorder, schizophrenia, or other psychotic disorder; AND (2) Patient is unable to ingest solid oral dosage forms due to one of the following: (i) oral/motor difficulties (ii) dysphagia; AND (3) Patient has had a trial and failure, intolerance or contraindication to at least ONE formulary alternative including risperidone ODT, risperidone, quetiapine, olanzapine, ziprasidone (medication usage must be supported by documentation from the patient's chart notes/medical records/electronic claim history).

ATOVAQUONE

Products Affected

- *atovaquone*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Treatment of more severe episodes of PCP. Patients who are failing therapy with TMP-SMX for PCP.
Required Medical Information	INITIAL/RENEWAL: PROPHYLAXIS OF PCP: Patients with HIV have documentation of one of the following: Must have a documented CD4 count of less than 200 cells/mm3 within the last 3 months; OR documentation the member had an episode of PCP that occurred at a CD4 count greater than 200cells/mm3 while the member was on antiretroviral therapy
Age Restrictions	13 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Infectious Disease specialist, oncologist, or HIV specialist.
Coverage Duration	INITIAL: PCP treatment: 21 days. PCP prophyl: 12 mos. RENEWAL: PCP prophly: 12 mos.
Other Criteria	INITIAL:TREATMENT OF PCP: Patient has a diagnosis of mild-to-moderate PCP; AND Patient has a documented trial and intolerance or contraindication to trimethoprim/sulfamethoxazole (TMP-SMX); AND Patient has a documented trial and treatment failure, intolerance, or contraindication to dapsone. PROPHYLAXIS OF PCP: Documentation of member that is immunocompromised that requires prevention of Pneumocystis carinii pneumonia (PCP); AND Patient has a documented trial and intolerance or contraindication to trimethoprim/sulfamethoxazole (TMP-SMX); AND Patient has a documented trial and treatment failure, intolerance, or contraindication to dapsone. RENEWAL: PROPHYLAXIS OF PCP: Prescriber attests that patient is responding positively to therapy; AND Prescriber provides documentation of patient compliance

AXITINIB

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

AZATHIOPRINE

Products Affected

- AZASAN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypersensitivity to azathioprine Use in pregnant women for treating rheumatoid arthritis.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has had a trial and therapeutic failure to generic azathioprine.

BETAINE

Products Affected

- *betaine*
- CYSTADANE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, a physician specializing in metabolic disorders and genetics
Coverage Duration	12 months
Other Criteria	None

BEXAROTENE

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

BOSUTINIB

Products Affected

- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	CHRONIC, ACCELERATED, OR BLAST PHASE PHILADELPHIA CHROMOSOME-POSITIVE (PH+) CHRONIC MYELOGENOUS LEUKEMIA (CML): 1) Breakpoint Cluster Region Abelson Murine Leukemia (BCR-ABL) mutational analysis confirming that the following mutations are NOT present: T315I, V299L, G250E, or F317L
Age Restrictions	18 year of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	CHRONIC, ACCELERATED, OR BLAST PHASE PH+ CML: 1) Trial of or contraindication to other tyrosine kinase inhibitors [e.g., Gleevec (imatinib), Sprycel (dasatinib), Tasigna (nilotinib)]

BREXPIPRAZOLE

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	SCHIZOPHRENIA: Patient has diagnosis of Schizophrenia; Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least THREE (3) formulary alternative antipsychotics including, but not limited to, risperidone, olanzapine, aripiprazole, ziprasidone, and quetiapine. MAJOR DEPRESSIVE DISORDER: Patient has diagnosis of Major Depressive Disorder; AND Patient will be using Rexulti in combination with other medication(s) used to treat MDD; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO formulary alternative antidepressants including, but not limited to fluoxetine, paroxetine, sertraline, citalopram, venlafaxine, bupropion, escitalopram, desvenlafaxine; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least THREE formulary alternative antipsychotics including, but not limited to olanzapine, aripiprazole, quetiapine ER.

BUPRENORPHINE PAIN

Products Affected

- BUPRENEX
- *buprenorphine hcl injection*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Use as an as-needed (prn) analgesic. (Butrans only) Significant respiratory depression. Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment. Known or suspected gastrointestinal obstruction, including paralytic ileus. Hypersensitivity to buprenorphine.
Required Medical Information	None
Age Restrictions	18 years of age or older prior to approval of Butrans 2 years of age or older prior to approval of Buprenex
Prescriber Restrictions	Prescribed by, or in consultation with, a pain management specialist.
Coverage Duration	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: (1) Butrans: Patient has a documented diagnosis of chronic, severe pain requiring long-term daily, around-the-clock opioid treatment; AND Patient has had a trial and failure, intolerance, or contraindication to alternative treatment options including non-opioid analgesics (e.g., NSAIDs) AND Patient has had a trial and failure, intolerance, or contraindication to an immediate-release opioid/opioid combination product. (2) Buprenex: Patient has a documented diagnosis of pain severe enough to require an opioid analgesic; AND Patient has had a trial and failure, intolerance, or contraindication to alternative treatment options including non-opioid analgesics (e.g., NSAIDs); AND Patient has had a trial and failure, intolerance, or contraindication to an immediate-release opioid/opioid combination product. RENEWAL: (1) Prescriber attests that patient continues to meet initial criteria.

BUSULFAN

Products Affected

- *busulfan*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	History of hypersensitivity to busulfan or any of its components
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of chronic myelogenous leukemia and is undergoing a conditioning regimen prior to allogeneic hematopoietic progenitor cell transplantation; AND patient is prescribed cyclophosphamide as part of conditioning regimen.

CALCIUM ACETATE

Products Affected

- PHOSLYRA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with hypercalcemia.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist
Coverage Duration	12 months
Other Criteria	Patient has diagnosis of hyperphosphatemia associated with chronic kidney disease, dialysis, end stage renal disease (ESRD), or renal failure; AND Patient is on a phosphate-restricted diet; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to calcium acetate AND sevelamer carbonate. NOTE: Therapeutic failure would be defined as phosphorus level greater than4.5mg/dl or calcium levels above 9.6 as documented by lab test for 2 to 3 consecutive months.

CAPECITABINE

Products Affected

- *capecitabine oral tablet 150 mg, 500 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Metastatic colorectal cancer: Use as monotherapy or in combination with oxaliplatin (CapeOX or XELOX)

CERITINIB

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): ONE of the following objective signs of inflammation: C-reactive protein (CRP) levels above the upper limit of normal OR Sacroiliitis on magnetic resonance imaging (MRI)
Age Restrictions	18 year of age or older
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA)/ANKYLOSING SPONDYLITIS (AS)/ (NR-AXSPA): prescribed by or given in consultation with a rheumatologist PSORIATIC ARTHRITIS (PSA): prescribed by or given in consultation with a rheumatologist or dermatologist CROHNS DISEASE (CD): prescribed by or given in consultation with a gastroenterologist (PSO): prescribed by or given in consultation with a dermatologist
Coverage Duration	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INIT: RA: 1) Trial of or contraindication (C/I) to at least 3 mo. of treatment with ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate (MTX) dose greater than or equal to 20mg per wk or maximally tolerated dose, leflunomide, hydroxychloroquine, or sulfasalazine 2) Patient meets ONE of the following: (a) Pregnant, breastfeeding, or trying to become pregnant (b) Trial of or C/I to any TWO of the following: Enbrel, Humira, Rinvoq, Xeljanz (IR/XR) (c) Trial of any TNF inhibitor (e.g., Humira, Enbrel) AND the physician has indicated the patient cannot use a JAK inhibitor (e.g., Rinvoq, Xeljanz IR/XR) due to the black box warning for increased risk of mortality, malignancies, and serious cardiovascular events PSA: 1) Trial of or C/I to ONE DMARD, such as MTX, leflunomide, hydroxychloroquine, or sulfasalazine 2) Patient meets ONE of following: a) Pregnant, breastfeeding, or trying to become pregnant OR b) Trial of or C/I to any TWO of the following: Cosentyx, Enbrel, Humira, Stelara, Xeljanz (IR/XR), Otezla, Tremfya, Rinvoq, Skyrizi. AS: 1) Trial of or C/I to an NSAID (e.g., ibuprofen, naproxen, meloxicam, diclofenac, etc.) 2) Patient meets ONE of the following: a) Pregnant, breastfeeding, or trying to become pregnant OR b) Trial of or C/I to any TWO of the following: Cosentyx, Enbrel, Humira, Xeljanz (IR/XR). CD: 1) Trial of or C/I to ONE conventional agent, such as corticosteroids (i.e., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine 2) Patient meets ONE of the following: (a) Pregnant, breastfeeding, or trying to become pregnant (b) Trial of or C/I to Humira. PSO: 1) Psoriasis covering 3% or more of body surface area (BSA) OR psoriatic lesions affecting the hands, feet, genital area, or face 2) Trial of or C/I to ONE or more conventional therapies, such as PUVA (Phototherapy Ultraviolet Light A), UVB (Ultraviolet Light B), topical corticosteroids, calcipotriene, acitretin, MTX, or cyclosporine 3) Patient meets ONE of the following: (a) Pregnant,

PA Criteria	Criteria Details
	breastfeeding, or trying to become pregnant (b) Trial of or C/I to any TWO of the following: Cosentyx, Humira, Stelara, Tremfya, Skyrizi, Enbrel, Otezla. NR-AXSPA: 1) Trial of or C/I to an NSAID 2) Patient meets ONE of the following: (a) C-reactive protein (CRP) levels above the upper limit of normalt (b) Sacroiliitis on magnetic resonance imaging (MRI). RNWL: RA/PSA: Patient experienced or maintained 20% or more improvement in tender joint count or swollen joint count while on therapy. AS/NR-AXSPA: Patient experienced or maintained an improvement of at least 50% or 2 units (scale of 1-10) in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) while on therapy. PSO: Patient achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more while on therapy. CD: Diagnosis of moderate to severe Crohns disease.

chlorambucil

Products Affected

- LEUKERAN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients whose disease has demonstrated a prior resistance to the Leukeran. Patients who have demonstrated hypersensitivity to chlorambucil and other alkylating agents.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of chronic lymphatic (lymphocytic) leukemia, malignant lymphomas including lymphosarcoma, giant follicular lymphoma, or Hodgkins disease; AND Leukeran is being used as palliative treatment.

CRIZOTINIB

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	ANAPLASTIC LARGE CELL LYMPHOMA (ALCL): 1 year of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CYCLOSPORINE SOLUTION

Products Affected

- SANDIMMUNE ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with a hypersensitivity to Sandimmune (cyclosporine) and/or Cremophor EL (polyoxyethylated castor oil).
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has had a trial and therapeutic failure, intolerance, or contraindication to BOTH of the following: cyclosporine capsule (generic Sandimmune capsule) AND Gengraf Solution 100mg/mL.

CYSTEAMINE

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	Contraindicated in patients who have developed hypersensitivity to cysteamine or penicillamine.
Required Medical Information	Patient has a diagnosis of nephropathic cystinosis confirmed by one of the following: Leukocyte cystine measurements greater than normal (nl range normal values are less than 0.2 nmol half-cystine/mg protein) OR DNA testing (two mutations in the CTNS gene, the only gene).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DACARBAZINE

Products Affected

- *dacarbazine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypersensitivity to dacarbazine or any of its components.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in collaboration with an oncologist
Coverage Duration	12 months
Other Criteria	A. Melanoma: Patient has diagnosis of metastatic malignant melanoma. B. Hodgkins Disease: Patient has a diagnosis of Hodgkins disease AND medication is given in combination with other effective drugs.

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Ampyra will not be covered in patients with any of the following exclusion criteria (1) The patient has a seizure disorder, OR (2) The patient has moderate renal impairment (defined as a creatinine clearance (CrCl) of 30-50 mL/min) or severe renal impairment (defined as a CrCl less than or equal to 50 mL/min), OR (3) The patient has a history of hypersensitivity to AMPYRA or 4-aminopyridine.
Required Medical Information	None
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a neurologist.
Coverage Duration	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: (1) Patient has a diagnosis of Indication of multiple sclerosis (MS); AND (2) Medical records/chart notes from neurology consultation documenting the deterioration of walking ability confirmed by gait assessment (e.g., MS Walking Scale 12 (MSWS-12), Timed 25-foot Walk (T25FW), 6-minute Walk Test, Expanded Disability Status Scale (EDSS), AND Documentation of past or current physical therapy AND (3) History of or current treatment with immune modulating therapies for MS. RENEWAL: (1) Medical records/chart notes from neurology consultation documenting the improvement of walking ability confirmed by gait assessment. NOTE- The Expanded Disability Status Score (EDSS) quantifies disability in eight functional systems: pyramidal, cerebellar, brainstem, sensory, bowel and bladder, visual, cerebral, and other. EDSS scores 1.0 to 4.5 refer to people with multiple sclerosis who are fully ambulatory. EDSS scores 5.0 to 9.5 are defined by increasing impairment to ambulation.

DANAZOL

Products Affected

- *danazol*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	Undiagnosed abnormal genital bleeding Markedly impaired hepatic, renal, or cardiac function Pregnancy Breast feeding Porphyria-Danazol capsules can induce ALA synthetase activity and hence porphyrin metabolism Androgen-dependent tumor Active thrombosis or thromboembolic disease and history of such events
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	ENDOMETRIOSIS: Prescribed by, or in consultation with, a gynecologist. HEREDITARY ANGIOEDEMA: Prescribed by or in consultation with an allergist/immunologist.
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	ENDOMETRIOSIS AMENABLE TO HORMONE MANAGEMENT: Patient has a diagnosis of endometriosis confirmed by laparoscopy; AND If the diagnosis is not confirmed by surgery, then chart documentation of an adequate work-up and the clinical rationale for the diagnosis must be provided; AND Patient has had an adequate trial of oral contraceptives and/or progestins with an inadequate response or significant side effects or must have a contraindication to these therapies. HEREDITARY ANGIOEDEMA: Patient has a diagnosis of hereditary angioedema; AND Danazol will be used as prophylactic therapy for the prevention of hereditary angioedema attacks.

DASATINIB

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	NEWLY DIAGNOSED Ph+ CML IN CHRONIC PHASE; RESISTANT Ph+ CML IN CHRONIC, ACCELERATED, MYELOID OR LYMPHOID BLAST PHASE, RESISTANT Ph+ ALL: 18 years of age or older. NEWLY DIAGNOSED Ph+ ALL; Ph+ CML IN CHRONIC PHASE: Pediatrics 1 year of age or older.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	RESISTANT Ph+ CML IN CHRONIC, ACCELERATED, MYELOID OR LYMPHOID BLAST PHASE: Breakpoint Cluster Region Abelson Murine Leukemia (BCR-ABL) mutational analysis is negative for T315I, V299L, T315A, or F317L/V/I/C mutations.

DEFERIPRONE

Products Affected

- FERRIPROX ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	RENEWAL: 2 lab values in the previous 3 months showing serum ferritin levels consistently greater than 500mcg/L
Age Restrictions	INITIAL/RENEWAL: Tablets: 8 years of age or older. Solution: 3 years of age or older.
Prescriber Restrictions	Prescribed by or given in consultation with a hematologist or hematologist/oncologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months
Other Criteria	INITIAL: (1) Trial of or contraindication to one of the following: Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine). (2) One of the following: (a) Patient is experiencing intolerable toxicities or clinically significant adverse effects, or has a contraindication to current chelators Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine) OR (b) Current chelation therapy (i.e., Exjade [deferasirox], Jadenu [deferasirox], or Desferal [deferoxamine]) is inadequate as defined by one of the following: (i) 2 lab values in the previous 3 months showing serum ferritin levels are consistently above 2500mcg/L or (ii) Evidence of cardiac iron accumulation (i.e., cardiac T2star MRI less than 10 milliseconds, iron induced cardiomyopathy, fall in LVEF, arrhythmia indicating inadequate chelation).

DENOSUMAB

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypocalcemia. Pregnancy.
Required Medical Information	OSTEOPOROSIS IN MEN AND WOMEN: Patient has a documented diagnosis of osteoporosis indicated by at least ONE of the following: (1) Hip DXA (femoral neck or total hip) or lumbar spine T-score less than or equal to -2.5 and/or forearm DXA 33% (one-third) radius, (2) T-score less than or equal to -1 or low bone mass and a history of fragility fracture to the hip or spine, (3) T-score between -1 and -2.5 with a FRAX 10-year probability for major fracture greater than or equal to 20% or hip fracture greater than or equal to 3%. TREATMENT OF BONE LOSS IN MEN WITH PROSTATE CANCER: Patient has a documented Hip DXA (femoral neck or total hip) or lumbar spine T-score less than or equal to -1 OR Patient has a documented diagnosis of osteoporosis indicated by at least ONE of the following: (1) Hip DXA (femoral neck or total hip) or lumbar spine T-score less than or equal to -2.5 and/or forearm DXA 33% (one-third) radius, (2) T-score less than or equal to -1 or low bone mass and a history of fragility fracture to the hip or spine, (3) T-score between -1 and -2.5 with a FRAX 10-year probability for major fracture greater than or equal to 20% or hip fracture greater than or equal to 3%.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	ALL INDICATIONS: Patient must be at high risk for fracture defined as one or more of the following: (1) History of an osteoporotic fracture as an adult, (2) Parental history of hip fracture, (3) Low BMI, (4) Rheumatoid arthritis, (5) Alcohol intake (3 or more drinks per day), (5) Current smoking, (6) History of oral glucocorticoids greater than or equal to 5 mg/d of prednisone (or equivalent) for greater than 3 months (ever). OSTEOPOROSIS IN MEN AND WOMEN: Patient is post-menopausal (Women ONLY); AND Patient has had a documented trial and therapeutic failure to a minimum (12) month trial with bisphosphonates (oral or IV) such as alendronate, risedronate, ibandronate, or zoledronic acid; OR Patient has a documented contraindication or intolerance to BOTH oral bisphosphonates AND intravenous (IV) bisphosphonates such as alendronate, risedronate, ibandronate, or zoledronic acid. GLUCOCORTICOID-INDUCED OSTEOPOROSIS: Patient will be initiating or is continuing systemic glucocorticoid therapy at a daily dosage equivalent to greater than or equal to 7.5 mg of prednisone and is expected to remain on glucocorticoid therapy for at least 6 months; AND Patient has had a documented trial and therapeutic failure to a minimum (12) month trial with bisphosphonates (oral or IV) such as alendronate, risedronate, ibandronate, or zoledronic acid; OR Patient has a documented contraindication or intolerance to BOTH oral bisphosphonates AND intravenous (IV) bisphosphonates such as alendronate, risedronate, ibandronate, or zoledronic acid. TREATMENT OF BONE LOSS IN MEN WITH PROSTATE CANCER: Patient is receiving androgen deprivation therapy for non-metastatic prostate cancer.

PA Criteria	Criteria Details
	TREATMENT OF BONE LOSS IN WOMEN WITH BREAST CANCER.: Patient is receiving adjuvant aromatase inhibitor therapy for breast cancer. NOTE: Therapeutic failure to previous therapy is defined as: (1) Decrease in T-score in comparison with baseline T-score from DXA scan AND/OR (2) Patient has a new fracture while on bisphosphonate therapy. Examples of contraindications to oral bisphosphonate therapy: (1) Documented inability to sit or stand upright for at least 30 minutes (2) Documented pre-existing gastrointestinal disorder such as inability to swallow, Barretts esophagus, esophageal stricture, dysmotility, or achalasia.

DESMOPRESSIN SOLUTION

Products Affected

- *desmopressin injection*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	Known hypersensitivity to desmopressin acetate. Patients with moderate to severe renal impairment (defined as a creatinine clearance below 50 mL/min). Patients with hyponatremia or a history of hyponatremia. Treatment of nephrogenic diabetes insipidus. Treatment of severe classic von Willebrands disease (Type I) and when there is evidence of an abnormal molecular form of factor VIII antigen. Treatment of hemophilia A with factor VIII coagulant activity levels equal to or less than 5%, or treatment of hemophilia B, or patients who have factor VIII antibodies.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Patient has a diagnosis of Central Cranial Diabetes Insipidus; AND Desmopressin is being used as antidiuretic replacement therapy; OR desmopressin is being used to treat temporary polyuria and polydipsia following head trauma or surgery in the pituitary region. Patient has a diagnosis of mild to moderate classic von Willebrands disease (Type I); AND (1) Patient has factor VIII levels greater than 5%; AND (2) Patient is undergoing a surgical procedure; OR Patient is experiencing an episode of bleeding due to spontaneous or trauma-induced injury such as hemarthroses, intramuscular hematomas or mucosal bleeding. Patient has a diagnosis of hemophilia A; AND (1) Patient has factor VIII coagulant activity levels greater than 5%; AND (2) Patient is undergoing a surgical procedure; OR Patient is experiencing an episode of bleeding due to spontaneous or trauma-induced injury such as hemarthroses, intramuscular hematomas or mucosal bleeding.

DIFENOXIN/ATROPINE

Products Affected

- MOTOFEN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	Patients with diarrhea associated with organisms that penetrate the intestinal mucosa (toxigenic E. coli, Salmonella species, Shigella) and pseudomembranous colitis associated with broad spectrum antibiotics. Patients with a known hypersensitivity to difenoxin, atropine, or any of the inactive ingredients. Patients who are jaundiced.
Required Medical Information	None
Age Restrictions	2 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of acute nonspecific diarrhea Or is experiencing an acute exacerbation of chronic functional diarrhea; AND Motofen is being used as adjunctive treatment; AND Patient has had a trial and therapeutic failure or intolerance to both of the following: loperamide (Capsule or Tablet) AND diphenoxylate/atropine (generic Lomotil).

DIHYDROERGOTAMINE MESYLATE NASAL

Products Affected

- *dihydroergotamine nasal*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Prophylactic therapy of migraine or for the Management of hemiplegic or basilar migraine. Coadministration with potent CYP3A4 inhibitors (ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin, troleandomycin, ketoconazole, itraconazole) Coadministration with peripheral or central vasoconstrictors Concomitant use or use within 24 hours of 5-HT1 receptor agonists (e.g., sumatriptan), ergotamine containing or ergot type medications, or methysergide Following vascular surgery Hemiplegic or basilar migraine Ischemic heart disease (e.g., angina pectoris, history of myocardial infarction, or documented silent ischemia) Patients having symptoms consistent with coronary artery vasospasm, including Prinzmetals variant angina Nursing mothers Peripheral arterial disease Pregnancy Sepsis Severe hepatic impairment Severe renal impairment Uncontrolled hypertension
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Patient has a diagnosis of moderate to severe migraine headaches with or without aura AND Patient has a documented intolerance to, contraindication, or treatment failure to TWO of the following oral triptans: (almotriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan) AND Patient has a documented intolerance to, contraindication, or treatment failure to sumatriptan nasal spray or sumatriptan injection (generic Imitrex)

DOCETAXEL

Products Affected

- *docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Neutrophil count less than 1500 cells/mm(3). History of severe hypersensitivity to products containing docetaxel.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	BREAST CANCER a. Patient has a diagnosis of locally advanced or metastatic breast cancer; AND has failed of prior chemotherapy. b. Patient has a diagnosis of operable node-positive breast cancer; AND docetaxel will be used in combination with doxorubicin and cyclophosphamide as adjuvant treatment. NON-SMALL CELL LUNG CANCER (NSCLC) a. Patient has a diagnosis of locally advanced or metastatic NSCLC; And patient has failed prior platinum-based chemotherapy; AND docetaxel will be used as a single agent. b. Patient has a diagnosis of unresectable, locally advanced, or metastatic NSCLC; AND patient has not previously received chemotherapy for this condition; AND docetaxel will be used in combination with cisplatin. PROSTATE CANCER Patient has a diagnosis of androgen independent (hormone refractory) metastatic prostate cancer; AND docetaxel will be used in combination with prednisone. GASTRIC ADENOCARCINOMA Patient has a diagnosis of advanced gastric adenocarcinoma, including adenocarcinoma of the gastroesophageal junction; AND patient has not received prior chemotherapy for advanced disease; AND docetaxel will be used in combination with cisplatin and fluorouracil. HEAD AND NECK CANCER Patient has a diagnosis of locally advanced squamous cell carcinoma of the head and neck (SCCHN); AND docetaxel will be used in combination with cisplatin and fluorouracil (5FU).

DORNASE ALFA

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DOXEPIN CREAM

Products Affected

- *doxepin topical*

PA Criteria	Criteria Details
Covered Uses	All FDA approved Indications.
Exclusion Criteria	Patients with untreated narrow angle glaucoma Patient with a tendency to urinary retention
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 month. IL: 12 months
Other Criteria	Patient has a diagnosis of moderate pruritis associated with atopic dermatitis OR lichen simplex chronicus; AND Patient has tried and failed previous treatment with at least TWO (2) topical steroid creams.

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Concurrent therapy with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
Required Medical Information	ATOPIC DERMATITIS: INITIAL: Prescriber attests that patient has greater than or equal to 10% body surface area (BSA) involvement ASTHMA: INITIAL: Patients peripheral blood eosinophil (EOS) count is greater than or equal to 150 cells per microliter
Age Restrictions	ASTHMA: 12 years of age or older ATOPIC DERMATITIS: 6 years of age or older RHINOSINUSITIS WITH NASAL POLYPS: 18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist, allergist, immunologist, asthma specialist, dermatologist, or otolaryngologist.
Coverage Duration	INITIAL: CRSwNP, AD: 6 mo, ASTHMA: 12 mo, RENEWAL: 12 mo. IL: 12 mo

PA Criteria	Criteria Details
Other Criteria	ATOPIC DERMATITIS: INITIAL: (1) Patient has documented diagnosis (supported by documentation from the patients chart notes/medical records) of moderate to severe atopic dermatitis AND (2) Must have tried and failed, have an intolerance or a contraindication to a 6-month trial of at least two of the three following options: a.) Very high or high potency topical steroid OR b.) Tacrolimus ointment or pimecrolimus cream OR c.) An immunosuppressive agent RENEWAL: (1) Documentation that the patient has responded to Dupixent therapy as determined by the prescribing physician (e.g., marked improvements in erythema, induration/papulation/edema, excoriations, and lichenification, reduced pruritus, decreased requirement for other topical or systemic therapies, reduced body surface area affected with atopic dermatitis, or other responses observed) MODERATE TO SEVERE ASTHMA: INITIAL: (1) Patient has moderate to severe asthma (supported by documentation from the patients chart notes/medical records) defined as current drug therapy including a.) Medium, high-dose, or max-tolerated inhaled corticosteroid (ICS) AND one additional asthma controller medication (long-acting beta 2-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist (LTRA), or theophylline) OR b.) Maximally tolerated ICS/LABA combination product AND (2) Patient has had one asthma exacerbation in previous 12 months (e.g. oral corticosteroid (OCS) burst, ER visit, hospital admission, urgent care visit) OR is dependent on chronic daily OCS for asthma control RENEWAL: Documentation that the treatment has resulted in clinical benefit defined as one or more of the following: a.) Decreased use of systemic corticosteroids b.) Increase in Forced Expiratory Volume (FEV1) from pretreatment baseline c.) Decreased use of inhaled corticosteroid use for at least 3 days d.) Decrease in

PA Criteria	Criteria Details
	hospitalizations e.) Decrease in ER visits OR f.) Decrease in unscheduled visits to healthcare provider. C. CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP): INITIAL: (1) Patient has a documented diagnosis (supported by documentation from the patients chart notes/medical records) of CRSwNP with the presence of nasal polyps AND (2) Patient has two or more of the following symptoms for greater than or equal to 12 weeks a.) mucopurulent discharge OR b.) nasal obstruction and congestion OR c.) decreased or absent sense of smell OR d.) facial pressure or pain AND (3) Patient is unable to achieve symptom relief after trial of intranasal corticosteroids AND (4) Patient will continue to use Dupixent in combination with intranasal corticosteroid therapy RENEWAL: Documentation that the patient has responded to Dupixent as determined by the prescribing physician.

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ENDOTHELIN RECEPTOR ANTAGONISTS

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): (1) Idiopathic pulmonary fibrosis (Letairis and Tracleer only), (2) Concurrently taking cyclosporine A or glyburide (Tracleer only).
Required Medical Information	INITIAL: PAH: (1) NYHA-WHO Functional Class II to IV symptoms AND (2) Right heart catheterization with the following parameters: (1) Mean pulmonary artery pressure (PAP) greater than 20 mmHg and (2) Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg and (3) Pulmonary vascular resistance (PVR) greater than or equal to 3 Wood units.
Age Restrictions	TRACLEER: PULMONARY ARTERIAL HYPERTENSION: 3 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	INITIAL/RENEWAL: PAH: 12 months.
Other Criteria	RENEWAL: PAH: APPROVAL FOR TRACLEER AND PATIENT IS 3 TO 17 YEARS OLD REQUIRES EITHER (1) improvement in pulmonary vascular resistance OR (2) patient has remained stable or shown improvement in exercise ability (e.g., 6-minute walk test, World Health Organization [WHO] functional class symptoms). APPROVAL FOR ALL OTHERS REQUIRES EITHER (1) improvement from baseline in the 6-minute walk distance test OR (2) patient is stable from baseline in the 6-minute walk distance test AND WHO functional class has remained stable or has improved.

EPOETIN ALFA-EPBX

Products Affected

- RETACRIT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications. Anemia due to concurrent hepatitis C treatment with ribavirin plus an interferon alfa or peginterferon alfa will also be considered for approval.
Exclusion Criteria	None
Required Medical Information	INITIAL: A. ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD), ANEMIA DUE TO ZIDOVUDINE THERAPY, OR ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT: (1) Hemoglobin level of less than 10g/dL. B. ANEMIA DUE TO CANCER CHEMOTHERAPY: (1) Hemoglobin level of less than 11g/dL OR (2) Hemoglobin level has decreased at least 2g/dL below baseline level. C. ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY: (1) Hemoglobin level of less than 13g/dL. RENEWAL: A. ANEMIA DUE TO CKD: One of the following: (1) hemoglobin level of less than 10g/dL if not on dialysis OR (2) hemoglobin level of less than 11g/dL if on dialysis OR (3) hemoglobin level has reached 10g/dL (if not on dialysis) and dose reduction/interruption is required to reduce the need for blood transfusions, OR (4) hemoglobin level has reached 11g/dL (if on dialysis) and dose reduction/interruption is required to reduce the need for blood transfusions. B. ANEMIA DUE TO CANCER CHEMOTHERAPY, DUE TO ZIDOVUDINE THERAPY, OR DUE TO CONCURRENT HEPATITIS C TREATMENT: (1) Hemoglobin level between 10g/dL and 12g/dL.
Age Restrictions	None
Prescriber Restrictions	None

PA Criteria	Criteria Details
Coverage Duration	ANMIA CKD, CANCER CHEM, ZDV: 12 mo. ANMIA HEP C: 6 mo INIT: SURGERY: 1 mo. IL: 12 mo chronic
Other Criteria	INITIAL: A. ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT: (1) Trial of or contraindication to ribavirin dose reduction.

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months
Other Criteria	INITIAL: EPISODIC MIGRAINES: Trial of ONE of the following preventative migraine treatments: valproic acid/divalproex sodium, topiramate, propranolol, timolol, metoprolol, amitriptyline, venlafaxine, atenolol, nadolol CHRONIC MIGRAINES: Trial of ONE of the following preventative migraine treatments: valproic acid/divalproex sodium, topiramate, propranolol, timolol, metoprolol, amitriptyline, venlafaxine, atenolol, nadolol, or Botox [Note: For Botox, previous trial of only NDCs # 00023-1145-01 or 00023-3921-02 are allowable] RENEWAL: ONE of the following: (1) Patient has experienced a reduction in migraine or headache frequency of at least 2 days per month with Aimovig therapy OR (2) Patient has experienced a reduction in migraine severity with Aimovig therapy OR (3) Patient has experienced a reduction in migraine duration with Aimovig therapy

ERGOLOID MESYLATES ORAL

Products Affected

- *ergoloid*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Known hypersensitivity to ergoloid mesylates or in patients with known ergot alkaloid hypersensitivity. Ergoloid mesylate should not be used in patients acute or chronic psychosis regardless of etiology.
Required Medical Information	None
Age Restrictions	INITIAL/RENEWAL: 18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	INITIAL 1. Diagnosis of Alzheimers disease, vascular dementia, or primary progressive dementia supported by documentation. 2. Patient intolerance to, or adequate trial of TWO of the following: galantamine, donepezil or rivastigmine. RENEWAL 1. Documented positive clinical response to ergoloid therapy.

ERLOTINIB

Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ESTRAMUSTINE PHOSPHATE SODIUM

Products Affected

- EMCYT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with known hypersensitivity to either estradiol or to nitrogen mustard. Active thrombophlebitis or thromboembolic disorders, except in those cases where the actual tumor mass is the cause of the thromboembolic phenomenon.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of metastatic and/or progressive prostate cancer; AND Emcyt (extramustine phosphate sodium) is being used for palliative treatment.

ETANERCEPT

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	RHEUMATOID ARTHRITIS (RA), PSORIATIC ARTHRITIS (PsA), ANKYLOSING SPONDYLITIS (AS): 18 years of age or older POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): 2 years of age or older PSORIASIS (PsO): 4 years of age or older
Prescriber Restrictions	RA/PJIA/AS: Prescribed by or in consultation with a rheumatologist PsA: Prescribed by or in consultation with a rheumatologist or dermatologist PsO: Prescribed by or in consultation with a dermatologist
Coverage Duration	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: Trial of or contraindication to at least 3 months of treatment with ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate dose greater than or equal to 20mg per week or maximally tolerated dose, leflunomide, hydroxychloroquine, or sulfasalazine. PJIA: Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. PsA: Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. AS: Trial of or contraindication to an NSAID (e.g., naproxen, ibuprofen, diclofenac). PsO: (1) Psoriasis covering 3% or more of body surface area (BSA) or psoriatic lesions affecting the hands, feet, genital area, or face. (2) Trial of or contraindication at least one conventional therapy such as a PUVA (phototherapy ultraviolet light A), UVB (ultraviolet light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. RENEWAL: RA/PJIA/PsA: Patient experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. AS: Patient experienced or maintained an improvement of at least 50% or 2 units (scale of 1-10) in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) while on therapy. PsO: Patient achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more while on therapy.

ETHACRYNIC ACID

Products Affected

- *ethacrynic acid*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Patients with anuria. Patients that have experienced severe, watery diarrhea with previous treatment with ethacrynic acid
Required Medical Information	None
Age Restrictions	1 year of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	INITIAL: Patient has a documented diagnosis of edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome, ascites due to malignancy, idiopathic edema, or lymphedema; AND Patient has a documented sulfa allergy; OR Patient had a trial and therapeutic failure of a 30-day trial of furosemide, bumetanide, AND torsemide. RENEWAL: Prescriber attests that patient is responding positively to therapy; AND Patient has not experienced an increasing electrolyte imbalance, azotemia, and/or oliguria occur during treatment of severe, progressive renal disease; AND Patient has not experienced severe, watery diarrhea.

FENTANYL TRANSDERMAL PATCH

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Requests for every 48 hours dosing requires a trial of every 72 hours dosing

FIDAXOMICIN

Products Affected

- DIFICID

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	Patient has diagnosis of C. difficile-associated diarrhea (CDAD) confirmed by a positive stool assay
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	3 months
Other Criteria	Patient has had a trial and therapeutic failure, intolerance, or contraindication to oral vancomycin after a trial of at least 10 days. QTY LIMIT 20 per 10-day supply

FILGRASTIM

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	Granix: 1 month of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist
Coverage Duration	12 months
Other Criteria	Neupogen, Zarxio, Granix: Trial of or contraindication to Nivestym where indications align.

FINGOLIMOD

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	(1) recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure, (2) history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a functioning pacemaker, (3) baseline QTC interval 500 msec or above, or (4) Current treatment with Class Ia (quinidine, procainamide, or disopyramide) or Class III anti-arrhythmic drugs (amiodarone, dofetilide, dronedarone, ibutilide, or sotalol)
Required Medical Information	None
Age Restrictions	10 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

FONDAPARINUX

Products Affected

- *fondaparinux*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Severe renal impairment (creatinine clearance [CrCl] less than 30 mL/min) Active major bleeding. Bacterial endocarditis. Thrombocytopenia associated with a positive in vitro test for anti-platelet antibody in the presence of fondaparinux sodium. Body weight less than 50 kg (venous thromboembolism [VTE] prophylaxis only)
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Prophylaxis of Deep Vein Thrombosis Fondaparinux will be used as prophylaxis of deep vein thrombosis (DVT); AND patient is undergoing hip fracture surgery, including extended prophylaxis; OR patient is undergoing hip replacement surgery; OR patient is undergoing knee replacement surgery; OR patient is undergoing abdominal surgery who are at risk for thromboembolic complications. Treatment of Acute Deep Vein Thrombosis Patient has a diagnosis of acute deep vein thrombosis; AND fondaparinux will be administered in conjunction with warfarin sodium. Treatment of Acute Pulmonary Embolism Patient has a diagnosis of acute pulmonary embolism; AND fondaparinux will be administered in conjunction with warfarin sodium; AND initial therapy will be administered in the hospital.

FORMOTEROL

Products Affected

- *formoterol fumarate*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Treatment of asthma
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD); AND Patient has had a trial and therapeutic failure, contraindication, or intolerance to ALL of the following: Serevent, Spiriva, Stiolto Respimat, and Anoro Ellipta.

FULVESTRANT

Products Affected

- *fulvestrant*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Monotherapy Patient has a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer; AND Patient is a postmenopausal woman; AND Patient has not received prior endocrine therapy; OR Patient has a diagnosis of hormone receptor (HR)-positive advanced breast cancer; AND Patient is a postmenopausal woman; AND Patient has experienced disease progression following endocrine therapy. Combination Therapy Patient has a diagnosis of HR-positive, HER2-negative advanced or metastatic breast cancer; AND Patient is a postmenopausal woman; AND Patient will be using fulvestrant in combination with ribociclib as initial endocrine based therapy or following disease progression on endocrine therapy; OR Patient has a diagnosis of HR-positive, HER2-negative advanced or metastatic breast cancer; AND fulvestrant will be used in combination with palbociclib or abemaciclib; AND Patient has had disease progression after endocrine therapy.

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INIT: EPISODIC/CHRONIC MIG: 6 mo, EPISODIC CLUSTER HEAD: 3 mo. RNWL: 12 mo. IL: 12 mo

PA Criteria	Criteria Details
Other Criteria	INITIAL: EPISODIC MIGRAINES: Trial of ONE of the following preventative migraine treatments: valproic acid/divalproex sodium, topiramate, propranolol, timolol, metoprolol, amitriptyline, venlafaxine, atenolol, nadolol CHRONIC MIGRAINES: Trial of ONE of the following preventative migraine treatments: valproic acid/divalproex sodium, topiramate, propranolol, timolol, metoprolol, amitriptyline, venlafaxine, atenolol, nadolol, or Botox [Note: For Botox, previous trial of only NDCs # 00023-1145-01 or 00023-3921-02 are allowable] RENEWAL: EPISODIC/CHRONIC MIGRAINES: ONE of the following: (1) Patient has experienced a reduction in migraine or headache frequency of at least 2 days per month with Emgality therapy OR (2) Patient has experienced a reduction in migraine severity with Emgality therapy OR (3) Patient has experienced a reduction in migraine duration with Emgality therapy EPISODIC CLUSTER HEADACHE: Improvement in episodic cluster headache frequency as compared to baseline.

GEMCITABINE IV

Products Affected

- *gemcitabine intravenous recon soln 1 gram, 2 gram*
- *gemcitabine intravenous solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patient with known hypersensitivity to products containing gemcitabine.
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	OVARIAN CANCER: Patient has a diagnosis of advanced ovarian cancer; AND Patient has relapsed at least 6 months after completion of platinum-based therapy; AND Patient will be using gemcitabine in combination with carboplatin. BREAST CANCER: Patient has a diagnosis of metastatic breast cancer; AND Patient has previously failed anthracycline-containing adjuvant chemotherapy unless anthracyclines were clinically contraindicated; AND Patient will be using gemcitabine in combination with paclitaxel as first-line treatment. NON-SMALL CELL LUNG CANCER: Patient has a diagnosis of inoperable, locally advanced (Stage IIIA or IIIB), or metastatic (Stage IV) non-small cell lung cancer; AND Patient will be using gemcitabine in combination with cisplatin as first-line treatment. PANCREATIC CANCER: Patient has a diagnosis of locally advanced (nonresectable Stage II or Stage III) or metastatic (Stage IV) adenocarcinoma of the pancreas; AND Patient has been previously treated with 5-FU; AND gemcitabine is being used as first-line treatment.

GLATIRAMER ACETATE

Products Affected

- *glatiramer*
- *glatopa*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Patients with known hypersensitivity to glatiramer acetate or mannitol. Concurrent use of glatiramer acetate with interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia) or natalizumab (Tysabri)
Required Medical Information	None
Age Restrictions	Consistent with FDA approved label
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	INITIAL: (1) Patient has a diagnosis of relapsing-remitting MS (Note: Relapsing forms of MS include relapsing-remitting, secondary progressive with relapses, and progressive relapsing or clinically isolated MS) (2) 40mg/mL requests: (2a) Must be started and stabilized on Glatiramer, Glatopa, or Copaxone 20mg AND (2b) Must have valid medical reason why the 20mg daily dose cannot be used (i.e. clinically significant and intolerable post-injection reaction, individual requires assistance by caregiver to administer injections and caregiver is unable to administer injections on daily basis, etc. Convenience/preference is excluded.) RENEWAL: (1) Medical records/chart notes from neurology consultation documenting the improvement of the relapsing rate or that the patients clinical condition is stabilized with the current therapy with no significant adverse effects.

GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST (LEUPROLIDE)

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)
- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications and gender dysphoria will also be considered for approval.
Exclusion Criteria	None
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): (1) Elevated levels of follicle-stimulating hormone (level greater than 4.0 mIU/mL for females or greater than 5.0 mIU/mL for males) AND luteinizing hormone (level greater than 0.2 to 0.3 mIU/mL) at diagnosis.
Age Restrictions	CENTRAL PRECOCIOUS PUBERTY: 2 years of age or older.
Prescriber Restrictions	CPP: Prescribed by or in consultation with a pediatric endocrinologist
Coverage Duration	INIT/RNWL: GENDER DYSPHORIA, PROSTATE CANCER, or CPP: 12 m
Other Criteria	INITIAL: CPP (1) Younger than 8 years of age (females) or 9 years of age (males) at the onset of CPP AND (2) Documentation of pubertal staging using the Tanner scale for breast development (females) or genital development (males) (stage 2 or above) AND pubic hair growth (stage 2 or above). RENEWAL: CPP: (1) Tanner scale staging at initial diagnosis of CPP has stabilized or regressed during three separate medical visits in the previous year AND (2) Patient has not reached actual age which corresponds to current pubertal age.

GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST (NSA)

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)
- LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications and gender dysphoria will also be considered for approval.
Exclusion Criteria	None
Required Medical Information	CENTRAL PRECOCIOUS PUBERTY (CPP): (1) Elevated levels of follicle-stimulating hormone (level greater than 4.0 mIU/mL for females or greater than 5.0 mIU/mL for males) AND luteinizing hormone (level greater than 0.2 to 0.3 mIU/mL) at diagnosis
Age Restrictions	CENTRAL PRECOCIOUS PUBERTY (CPP): 2 years of age or older.
Prescriber Restrictions	ENDOMETRIOSIS: Prescribed by or in consultation with an obstetrician/gynecologist. CPP: Prescribed by or in consultation with a pediatric endocrinologist
Coverage Duration	INIT: UTERINE LEIOMY: 3 mo. INIT/RNWL: GENDR DYSPH, PROST CNCR, or CPP: 12 mo. ENDOMTRSIS: 6 mo.

PA Criteria	Criteria Details
Other Criteria	INITIAL: A. ENDOMETRIOSIS: (1) Trial of or contraindication to a nonsteroidal anti-inflammatory drug (NSAID) AND a progestin-containing contraceptive preparation (e.g., combination hormonal contraceptive preparation, progestin-only contraceptive preparation). B. CPP (1) Younger than 8 years of age (females) or 9 years of age (males) at the onset of CPP AND (2) Documentation of pubertal staging using the Tanner scale for breast development (females) or genital development (males) (stage 2 or above) AND pubic hair growth (stage 2 or above). RENEWAL: A. ENDOMETRIOSIS: (1) Improvement of pain related to endometriosis while on therapy AND (2) Patient is receiving concomitant add-back therapy (i.e., combination estrogen-progestin or progestin-only contraceptive preparation) AND (3) patient has NOT received a total course of therapy exceeding 12 months. B. CPP: (1) Tanner scale staging at initial diagnosis of CPP has stabilized or regressed during three separate medical visits in the previous year AND (2) Patient has not reached actual age which corresponds to current pubertal age.

GUSELKUMAB

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	PSORIASIS (PsO): Prescribed by or in consultation with a dermatologist. PSORIATIC ARTHRITIS (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months
Other Criteria	INITIAL: PsO: (1) Psoriasis covering 3% or more of body surface area, OR psoriatic lesions affecting the hands, feet, genital area, or face, AND (2) Trial of or contraindication at least one conventional therapy such as a PUVA (phototherapy ultraviolet light a), UVB (ultraviolet light b), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. PsA: Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drugs), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. RENEWAL: PsO: Achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more. PsA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count

HEREDITARY ANGIOEDEMA (PA)

Products Affected

- *icatibant*
- *sajazir*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: History of anaphylactic or life-threatening hypersensitivity reactions to human C1 inhibitor, icatibant, ecellantide or any component of the formulation.
Required Medical Information	INITIAL: HAE ACUTE (ICATIBANT), HAE PROPHYLAXIS (TAKHZYRO): (1) The patient has a diagnosis of Type I or Type II hereditary angioedema (HAE) evidenced by ONE of the following: a. BOTH of the following (there must be TWO separate low measurements for each test defined as below the testing laboratorys lower limit of the normal range): i. Low Serum complement factor 4 (C4) level AND ii. EITHER Low C1-INH antigenic level OR Low C1-INH functional level OR b. The patient has a mutation in the C1INH gene altering protein synthesis and/or function
Age Restrictions	Takhzyro: 12 years and older; Icatibant: 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with medical geneticist, allergist, immunologist, or hematologist
Coverage Duration	Initial: 6 months. Renewal: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: HAE ACUTE (ICATIBANT): (1) Medications known to cause angioedema have been evaluated and discontinued if appropriate (i.e. ACE-I, ARBs, estrogens) AND (2) Patient is experiencing at least one (1) symptom of moderate to severe HAE attack (i.e. airway swelling, severe abdominal pain, facial swelling, nausea/vomiting, painful facial distortion) AND (3) Patient is receiving only ONE agent indicated for treatment of acute HAE attack OR the other agent being used for acute HAE attacks will be discontinued before the starting requested agent INITIAL: HAE PROPHYLAXIS (TAKHZYRO): (1) The requested agent will be used for prophylaxis against HAE attacks AND a. The patient is receiving only ONE agent indicated for prophylaxis against HAE attacks OR b. The other agent being used for prophylaxis will be discontinued before starting the requested agent AND c. The patient has had at least 2 acute severe attacks per month (i.e. swelling of the throat, cutaneous or incapacitating abdominal swelling) AND (2) Medications known to cause angioedema have been evaluated and discontinued if appropriate (i.e. ACE-I, ARBs, and estrogens) AND (3) Member has tried and failed, intolerant to, or has a contraindication to danazol (4) The prescribed dosage follows Food and Drug Administration label unless there is documented clinical reasoning for higher dosage RENEWAL: HAE ACUTE (ICATIBANT): (1) Member has experienced a significant improvement in severity and duration of attacks yet continues to have occurrence of acute attacks AND (2) The patient continues to have occurence of acute attacks (3) The prescriber has communicated (via any means) with the patient regarding frequency and severity of attacks and has verified patient does not have greater than 1 month supply (sufficient for 2 acute
	attacks) currently on-hand. icatibant 6 syringes/30 days RENEWAL: HAE PROPHYLAXIS (TAKHZYRO): (1) Documented decrease in HAE attack frequency AND (2) Decrease in severity and duration of attacks (Note to prescriber: Consider increasing dosing interval to every 4 weeks if patient attack free for 6 months)

HYDROCODONE ER

Products Affected

- *hydrocodone bitartrate oral capsule, oral only, er 12hr*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Significant respiratory depression Acute or severe bronchial asthma or hypercarbia Patient has or is suspected of having paralytic ileus Hypersensitivity to any components of Hysingla ER or the active ingredient, hydrocodone bitartrate
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	AROUND-THE-CLOCK SEVERE-CHRONIC PAIN IN OPIOID TOLERANT PATIENTS: (1) Prescriber attests patient has diagnosis of Around-the-clock severe-chronic pain, in opioid-tolerant patients (2) The patient is 18 years of age or older (3) The patient must have severe pain enough to require daily, around-the clock, long-term opioid treatment (4) Patient has had inadequate pain control or intolerance to a two-week trial of at least 1 non-opioid and a 2-week trial of 1 short-acting opioid (5) Not indicated as an as-needed (PRN) analgesic

HYDROMORPHONE ER

Products Affected

- *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Dosages above 16mg require recommendation from a pain specialist
Coverage Duration	12 months
Other Criteria	None

IBRUTINIB

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	IBRUTINIB 140MG AND 280MG TABLETS: Requires trial of or contraindication to Ibrutinib 140mg capsules.

ILOPROST

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: (1) Documented confirmatory PAH diagnosis based on right heart catheterization with the following parameters: (a) Mean pulmonary artery pressure (PAP) greater than 20 mmHg, (b) Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg, and (c) Pulmonary vascular resistance (PVR) greater than or equal to 3 Wood units (WU). (2) Patient has NYHA/WHO Functional Class III-IV symptoms.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: One of the following: (1) WHO Functional Class III symptoms with trial of or contraindication to two of the following agents from different drug classes: (a) Oral endothelin receptor antagonist (e.g., ambrisentan, bosentan, or macitentan), (b) Oral phosphodiesterase-5 inhibitor (e.g., sildenafil or tadalafil), (c) Oral cGMP inhibitor (e.g., riociguat), OR (2) WHO Functional Class III symptoms with evidence of rapid progression/poor prognosis or WHO Functional Class IV symptoms, with trial of or contraindication to one IV/SQ prostacyclin (e.g., epoprostenol or treprostinil). RENEWAL: One of the following: (1) Patient had improvement from baseline in the 6-minute walk distance test, OR (2) Patient remained stable from baseline in the 6-minute walk distance test and the patients WHO functional class remained stable or has improved.

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	RELAPSED OR REFRACTORY PHILADELPHIA CHROMOSOME POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA (PH+ ALL); MYELODYSPLASTIC/MYELOPROLIFERATIVE; AGGRESSIVE SYSTEMIC MASTOCYTOSIS (ASM); HYPEREOSINOPHILIC SYNDROME (HES) AND/OR CHRONIC EOSINOPHILIC LEUKEMIA (CEL); DERMATOFIBROSARCOMA PROTUBERANS (DFSP); ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 18 years of age or older.
Prescriber Restrictions	None
Coverage Duration	ADJUV GASTROINTESTINAL STROMAL TUMOR: 36 mo. ALL OTHER DIAGNOSES: 12 mo
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): No previous treatment with another tyrosine kinase inhibitor.

IMMUNE GLOBULIN

Products Affected

- HYQVIA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications. Primary Immunodeficiency Disease (PID).
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Subcutaneous Use Only. Primary immunodeficiency disease only.

INTERFERON ALFA-2B

Products Affected

- INTRON A INJECTION RECON SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with: Autoimmune hepatitis, decompensated liver disease, Combination therapy with ribavirin in pregnant women or in men whose female partner are pregnant, patients with hemoglobinopathies (e.g., thalassemia major, sickle cell anemia), patients with creatinine clearance less than 50 mL/min
Required Medical Information	CHRONIC HEPATITIS C: Patient has diagnosis of chronic hepatitis C - genotype 1, 2, 3, 4, 5, 6 with detectable HCV RNA levels. CHRONIC HEPATITIS B: Patient has diagnosis of chronic hepatitis B with compensated liver disease confirmed by the detection of one of the following: (i) HBV viral RNA (ii) Hepatitis B surface antigen (HBsAG) (iii) Hepatitis Be antigen (HBeAG).
Age Restrictions	HAIRY CELL LEUKEMIA, MALIGNANT MELANOMA, FOLLICULAR LYMPHOMA, CONDYLOMATA ACUMINATA, AIDS RELATED KAPOSI SARCOMA: 18 years of age or older . CHRONIC HEPATITIS C: 3 years of age or older when treated with Rebetol, otherwise 18 years of age or older. CHRONIC HEPATITS B: 1 year of age or older.
Prescriber Restrictions	Must be prescribed by, or in conjunction with, a Gastroenterologist, Hepatologist, Oncologist or Infectious Disease Specialist
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	MALIGNANT MELANOMA: (1) Patient has diagnosis of malignant melanoma (disease free but at high risk for systemic recurrence) (2) Will be used as adjuvant to surgical treatment (within 56 days of surgery). FOLLICULAR NON-HODKINS LYMPHOMA: (1) Patient has diagnosis of clinically aggressive follicular Non-Hodgkin lymphoma (2) Will be used in conjunction with an anthracycline-containing chemotherapy regimen (3) Not being used in patients with low-grade, low-tumor burden follicular Non-Hodgkins Lymphoma. CONDYLOMATA ACUMINATA: Patient has diagnosis of condylomata acuminata involving external surfaces of the genital and perianal areas. AIDS-RELATED KAPOSI SARCOMA: Patient has diagnosis of AIDS-related Kaposi sarcoma. CHRONIC HEPATITIS C: (1) Trial/failure/contraindication to all appropriate formulary direct acting anti-viral therapies. (2) No history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation.

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	CHRONIC GRANULOMATOUS DISEASE (CGD): Prescribed by or given in consultation with a hematologist, infectious disease specialist, or immunologist SEVERE MALIGNANT OSTEOPETROSIS (SMO): Prescribed by or given in consultation with an endocrinologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months
Other Criteria	RENEWAL: CGD, SMO: 1) Patient has demonstrated clinical benefit compared to baseline (e.g., reduction in frequency and severity of serious infections) 2) Patient has not received hematopoietic cell transplantation

INTERFERONS FOR MULTIPLE SCLEROSIS

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	EXTAVIA: Trial of or contraindication to any TWO of the following formulary preferred agents for MS: Avonex, Copaxone/Glatiramer/Glatopa, Gilenya, Plegridy, Betaseron, dimethyl fumarate, Aubagio.

ISOTRETINOIN

Products Affected

- ABSORICA ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG
- *accutane*
- *amnesteem*
- *claravis*
- *isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg*
- *myorisan*
- *zenatane*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	INITIAL/RENEWAL: 12 years of age and older
Prescriber Restrictions	None
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	INITIAL: Patient has a diagnosis of severe recalcitrant nodular acne, treatment-resistant or scarring acne; AND Patient has had a trial and therapeutic failure with at least TWO (2) topical acne medications AND a trial of an oral tetracycline or tetracycline derivative. RENEWAL: Patient has had a relapse of severe recalcitrant nodular acne, treatment-resistant or scarring acne requiring a second treatment course; AND there is a gap of at least 2 months since completing the initial treatment course. QUANTITY RESTRICTION, Maximum 60 capsules / 30 days

ITRACONAZOLE ORAL

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Concomitant administration of itraconazole with drugs metabolized by CYP3A4: oral midazolam, pimozide, quinidine, dofetilide, triazolam, lovastatin, and simvastatin. Treatment of onychomycosis to pregnant patients or to women contemplating pregnancy. Patients who have shown hypersensitivity to itraconazole. Itraconazole capsules should not be administered for the treatment of onychomycosis in patients with evidence of ventricular dysfunction such as congestive heart failure (CHF) or a history of CHF.
Required Medical Information	ONYCHOMYCOSIS OF THE FINGERNAILS/TOENAILS: Prior to initiating treatment, appropriate nail specimens for laboratory testing (KOH preparation, fungal culture, or nail biopsy) should be obtained to confirm the diagnosis of onychomycosis.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Fingernl Onycho: 5 wk. Toenl Onycho: 12 wk. Histoplas/Blasto: 12 mo. Asperg: 6 mo. Candids: 2 mo

PA Criteria	Criteria Details
Other Criteria	ORAL CAPSULES ONLY Onychomycosis of the fingernails/toenails: Patient is not immunocompromised; AND Patient has had a trial and therapeutic failure, contraindication, or intolerance to 6 weeks of oral terbinafine for the fingernails OR 12 weeks of oral terbinafine for toenails. ORAL SOLUTION ONLY Esophageal Candidiasis: Patient has diagnosis of candidiasis of the esophagus with or without HIV; AND Patient has trial and failure, contraindication, or intolerance to 21-day trial of fluconazole. Oropharyngeal Candidiasis: Patient has diagnosis of oropharyngeal candidiasis with or without HIV. AND Patient has had a trial and therapeutic failure, contraindication, or intolerance to a 14-day treatment with fluconazole; AND Patient has had a trial and therapeutic failure, contraindication, or intolerance to a 14-day trial of nystatin suspension or clotrimazole troches.

IVABRADINE

Products Affected

- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Acute decompensated heart failure, Clinically significant hypotension (e.g., blood pressure less than 90/50 mm Hg), Sick sinus syndrome, sinoatrial block, or third-degree atrioventricular (AV) block (unless a functioning demand pacemaker is present), Clinically significant bradycardia (e.g., resting heart rate less than 60 bpm prior to treatment), Severe hepatic impairment, Pacemaker dependence (heart rate maintained exclusively by the pacemaker), Concomitant use with strong CYP3A4 inhibitors
Required Medical Information	INITIAL: A. STABLE, SYMPTOMATIC HEART FAILURE (NYHA II-IV) (1) Left ventricular ejection fraction less than or equal to 35% AND (2) Resting heart rate greater than or equal to 70 beats per minute. B. SYMPTOMATIC NYHA CLASS II-IV HEART FAILURE DUE TO DILATED CARDIOMYOPATHY (1) Patient has a resting heart rate of greater than or equal to 70 beats per minute
Age Restrictions	Stable, symptomatic heart failure (NYHA II-IV): 18 years of age or older, Symptomatic NYHA class II-IV heart failure due to dilated cardiomyopathy: 6 months of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: A. STABLE, SYMPTOMATIC HEART FAILURE (NYHA II-IV) (1) Patient has a diagnosis of stable, symptomatic heart failure (NYHA II-IV) AND (2) In sinus rhythm AND (3) Have symptoms despite maximal beta-blocker therapy or have documented contraindication to beta-blocker use AND (4) Trial, failure, or contraindication to ACE-inhibitor or ARB therapy B. SYMPTOMATIC NYHA CLASS II-IV HEART FAILURE DUE TO DILATED CARDIOMYOPATHY (1) Patient has diagnosis of symptomatic NYHA class II-IV heart failure due to dilated cardiomyopathy AND (2) In sinus rhythm. RENEWAL CRITERIA: (1) patient continues to meet initial criteria AND (2) patient has experienced disease stabilization or improvement with medication as determined by the prescriber.

LANREOTIDE

Products Affected

- *lanreotide*
- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: ACROMEGALY Prescriber must provide the following baseline documentation from patients medical record: 1) Elevated serum IGF-1 level for patients age range and gender, 2) Elevated growth hormone level defined by a GH level greater than or equal to 1 ng/mL during oral glucose tolerance test (OGTT). RENEWAL: ACROMEGALY Patient has documented disease response confirmed by reduction of growth hormone (GH) and/or IGF-I blood levels from baseline. AND Serum insulin-like growth factor-I (IGF-I) levels remain outside normal limits.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	INITIAL: ACROMEGALY Patient has a documented diagnosis of Acromegaly; AND Patient has had an inadequate response to surgery and/or radiation therapy; OR Documentation has been provided to confirm surgery and radiation therapy are not appropriate.

LAPATINIB

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LASMIDITAN

Products Affected

- REYVOW

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL: 6 months, RENEWAL: 12 months
Other Criteria	INITIAL: Trial of or contraindication to ONE triptan (e.g., sumatriptan, rizatriptan). RENEWAL: The patient has experienced an improvement from baseline in a validated acute treatment patient-reported outcome questionnaire OR the patient has experienced clinical improvement as defined by one of the following: (1) Ability to function normally within 2 hours of dose, (2) Headache pain disappears within 2 hours of dose, (3) Therapy works consistently in majority of migraine attacks.

LEDIPASVIR/SOFOSBUVIR

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	(1) Currently taking any of the following medications: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, rosuvastatin, simeprevir, sofosbuvir, the combination agent Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir), or the combination agent tipranavir/ritonavir. (2) Limited life expectancy (less than 12 months) due to non-liver related comorbid conditions (e.g., physician attestation).
Required Medical Information	Recent HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months
Age Restrictions	3 years of age or older
Prescriber Restrictions	Currently supervised by a gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (for example, a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model
Coverage Duration	Coverage duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(1) Criteria will be applied consistent with current AASLD/IDSA guidance. (2) Requests for Harvoni 45mg/200mg pellets require that the patient is unable to swallow tablets.

LENALIDOMIDE

Products Affected

- *lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg*
- REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	MULTIPLE MYELOMA: Revlimid (lenalidomide) will be used as induction treatment

LENVATINIB

Products Affected

- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	RENAL CELL CARCINOMA (RCC): 18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LEVOFLOXACIN OPHTHALMIC

Products Affected

- *levofloxacin ophthalmic (eye) drops 0.5%*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with a history of hypersensitivity to levofloxacin or other quinolones
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	Patient has diagnosis of Bacterial Conjunctivitis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO (2) of the following: ciprofloxacin 0.3% ophthalmic solution, tobramycin 0.3% ophthalmic solution, ofloxacin 0.3% ophthalmic solution

LIDOCAINE PATCH 5%

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications and Diabetic peripheral neuropathy
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	POSTHERPETIC NEURALGIA Patient has a diagnosis of post-herpetic neuralgia (shingles or herpes zoster); AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to Xylocaine (Lidocaine 2.5% or 4.0% solution, Lidocaine 2.5% or 3% cream, Lidocaine 2% gel) OR Capsaicin 0.025%, 0.075%, 0.1% cream (medication usage must be supported by documentation from the patients chart notes/medical records); AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to gabapentin (medication usage must be supported by documentation from the patients chart notes/medical records) DIABETIC PERIPHERAL NEUROPATHY Patient has had a diagnosis of diabetic peripheral neuropathy; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to Xylocaine (Lidocaine 2.5% or 4.0% solution, Lidocaine 2.5% or 3% cream, Lidocaine 2% gel) OR Capsaicin 0.025%, 0.075%, 0.1% cream (medication usage must be supported by documentation from the patients chart notes/medical records); AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to a one month trial of ALL of the following (medication usage must be supported by documentation from the patients chart notes/medical records): At least TWO (2) tricyclic antidepressants (amitriptyline, desipramine, imipramine, and nortriptyline) AND a traditional anticonvulsant (eg., carbamazepine, sodium valproate) AND venlafaxine AND duloxetine.

LOMUSTINE

Products Affected

- GLEOSTINE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	PRIMARY AND METASTATIC BRAIN TUMORS: 1) Requested medication will be used as a part of the PCV regimen (procarbazine, lomustine, and vincristine) OR 2) Patient had trial of IV carmustine

LUMACAFTOR-IVACAFTOR

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: Documentation that the patient is homozygous for the F508del-CFTR gene mutation
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or given in consultation with a pulmonologist or CF expert
Coverage Duration	INITIAL: 24 weeks. RENEWAL: Lifetime. IL: Initial 12 mo, Renewal: Lifetime
Other Criteria	RENEWAL: Improvement in clinical status as shown by one of the following: (a) Patient has improved, maintained, or demonstrated less than expected decline in FEV1 (forced expiratory volume), (b) Patient has improved, maintained, or demonstrated less than expected decline in BMI (body mass index), or (c) Reduction in rate of pulmonary exacerbations.

LURASIDONE

Products Affected

- LATUDA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Strong CYP3A4 inhibitors (e.g., ketoconazole, clarithromycin, ritonavir, voriconazole, mibefradil, etc.). Strong CYP3A4 inducers (e.g., rifampin, avasimibe, St. Johns wort, phenytoin, carbamazepine, etc.).
Required Medical Information	None
Age Restrictions	Bipolar depression: 10 years of age and older Schizophrenia: 13 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a psychiatrist.
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of major depressive episode associated with bipolar I disorder (bipolar depression) or schizophrenia; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least THREE (3) of the following (medication usage must be supported by documentation from the patients chart notes/medical records electronic claim history): risperidone, quetiapine, olanzapine, ziprasidone, aripiprazole.

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	2 years to less than 18 years of age
Prescriber Restrictions	Prescribed by or in consultation with a pediatric endocrinologist or a pediatric nephrologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months
Other Criteria	INITIAL: (1) Height standard deviation score of less than or equal to -3.0, (2) Basal IGF-1 standard deviation score of less than or equal to -3.0, (3) Normal or elevated growth hormone (GH), [serum growth hormone level of greater than equal to 10ngm/mL to at least two stimuli (insulin, levodopa, arginine, clonidine, or glucagon)], AND (4) Epiphyses (bone growth plates) is open (as confirmed by radiograph of the wrist and hand). RENEWAL: Shown response in the first 6 months of IGF-1 therapy (i.e., increase in height, increase in height velocity)

MELPHALAN

Products Affected

- *melphalan*
- *melphalan hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients whose disease has demonstrated a prior resistance to this agent. Patients who have demonstrated hypersensitivity to melphalan
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	ORAL TABLET: Patient has a diagnosis of multiple myeloma OR non-resectable epithelial carcinoma of the ovary; AND diagnosis is supported by chart notes/documentation; AND melphalan is being used for palliative treatment. INTRAVENOUS INJECTION: Patient has a diagnosis of multiple myeloma; AND diagnosis is supported by chart notes/documentation; AND melphalan is being used for palliative treatment; AND oral melphalan therapy is not appropriate (dysphagia, difficulty swallowing, etc.).

MEMANTINE ORAL SOLUTION

Products Affected

- *memantine oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Known hypersensitivity to memantine hydrochloride
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic memantine tablets; AND Patient is unable to ingest solid oral dosage forms due to one of the following: Oral/motor difficulties; OR Dysphagia.

MESNA

Products Affected

- MESNEX ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a Hematologist or Oncologist
Coverage Duration	12 months
Other Criteria	None

METHOXSALEN

Products Affected

- *methoxsalen*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients exhibiting idiosyncratic reactions to psoralen compounds. Patients possessing a specific history of light-sensitive disease states (e.g., lupus erythematosus, porphyria cutanea tarda, erythropoietic protoporphyria, variegate porphyria, xeroderma pigmentosum, and albinism) Patients with melanoma or with a history of melanoma. Patients with invasive squamous cell carcinomas. Patients with aphakia because of the significantly increased risk of retinal damage due to the absence of lenses.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of severe, recalcitrant, disabling psoriasis; AND Patients diagnosis is supported by biopsy (submission of supporting chart notes required); AND Patients disease is not adequately responsive to other forms of therapy; AND methoxsalen will be used in conjunction with a schedule of controlled doses of long wave ultraviolet radiation.

MITOTANE

Products Affected

- LYSODREN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	12 months
Other Criteria	None

MODAFINIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypersensitivity to modafinil or armodafinil.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep specialist.
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	NARCOLEPSY: Patient has a diagnosis of narcolepsy supported by a sleep study [documentation required]; AND Documentation has been provided to confirm diagnosis of narcolepsy is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication); AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least one formulary/preferred treatment, such as methylphenidate or dextroamphetamine. SHIFT WORK SLEEP DISORDER: Patient is experiencing excessive sleepiness and working a minimum of five (or more) overnight shifts per month [Documentation of current work schedule is required]; AND Documentation has been provided to confirm sleep disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. OBSTRUCTIVE SLEEP APNEA: Patient has a diagnosis of obstructive sleep apnea is supported by a sleep study [documentation required]; AND Patient is experiencing residual excessive sleepiness defined as an Epworth Sleepiness Scale (ESS) score of greater than or equal to 10; AND Patient has been on CPAP for at least 2 months and is using it on average greater than or equal to 4 hours per night.

NILUTAMIDE

Products Affected

- *nilutamide*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with severe hepatic impairment (baseline hepatic enzymes should be evaluated prior to treatment). Patients with severe respiratory insufficiency
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of metastatic prostate cancer (Stage D2) AND Patient is undergoing surgical castration AND Patient will begin nilutamide therapy on the same day as or on the day after surgical castration.

OCTREOTIDE

Products Affected

- *octreotide acetate*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: ACROMEGALY Baseline growth hormone (GH) and/or IGF-I blood levels are submitted for documentation. RENEWAL: ACROMEGALY Patient has documented disease response confirmed by reduction of growth hormone (GH) and/or IGF-I blood levels from baseline AND Serum insulin-like growth factor-I (IGF-I) levels remain outside normal limits.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	INITIAL: ACROMEGALY: Patients has had an inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses. ALL DIAGNOSES: REQUESTS FOR SANDOSTATIN LAR: Patient must have responded to and tolerated octreotide injection.

OLAPARIB

Products Affected

- LYNPARZA ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: (1) Medication used as monotherapy, (2) Medication started no later than 8 weeks after most recent platinum containing regimen, AND (3) Completed two or more lines of platinum based chemotherapy. ADVANCED GERMLINE BRCA MUTATED OVARIAN CANCER: Medication will be used as monotherapy. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC): One of the following: 1) Previously received a bilateral orchiectomy, 2) Concurrent use with a gonadotropin releasing hormone (GNRH) analog, OR 3) Castrate testosterone level (i.e., less than 50 ng/dL).

PALBOCICLIB

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has not experienced disease progression following prior CDK inhibitor therapy

PALIPERIDONE TAB ER

Products Affected

- *paliperidone*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypersensitivity to risperidone
Required Medical Information	None
Age Restrictions	12 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has diagnosis of schizophrenia or schizoaffective disorder; AND Patient has had a trial and failure, intolerance, or contraindication to at least TWO (2) of the following: risperidone, olanzapine, ziprasidone, quetiapine, aripiprazole.

PALIVIZUMAB

Products Affected

- SYNAGIS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	1. Any indication other than those listed in Other Criteria due to insufficient evidence of therapeutic value 2. Infants with cardiac lesions adequately corrected by surgery (unless pharmacological management is required for CHF) 3. Infants with CLD not requiring medical support in the 2nd year of life 4. Infants with mild cardiomyopathy, which does not require pharmacotherapy 5. Synagis use as routine prophylaxis for any of the following conditions: a. Down syndrome (unless qualifying heart disease, CLD/BPD, airway clearance issues or prematurity [less than 29 weeks, 0 days gestation] is present) b. Nosocomial disease prevention c. Primary asthma prevention (or for reduction of subsequent wheezing episodes) in infants and children 6. Synagis use as prophylaxis in any of the following scenarios: a. Outside of RSV "season" as defined by Centers for Disease and Prevention (CDC) surveillance reports or state or local health departments b. Dosing in excess of 5 doses per single RSV "season" as defined by Centers for Disease and Prevention (CDC) surveillance reports or state or local health departments c. Monthly Synagis administration as prophylaxis post breakthrough RSV hospitalization during the current season (if child had met criteria for palivizumab) 7. Treatment of symptomatic RSV disease
Required Medical Information	See Other Criteria
Age Restrictions	See Other Criteria

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	Max 5 months of Synagis (15 mg/kg body weight per dose) w/ last dose given in March or per CDC
Other Criteria	Synagis is approved for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients who meet at least one of the following criteria: 1. Early Preterm Infants a. Infants born before 29 weeks, 0 days gestation and younger than 12 months of age at the start of RSV season 2. Chronic Lung Disease of Prematurity (CLD)/Bronchopulmonary dysplasia (BPD) a. Infants younger than 12 months of age at the start of RSV season: i. Preterm infants who develop CLD/BPD of prematurity (defined as gestational age less than 32 weeks, 0 days AND a requirement for greater than 21% of oxygen for at least the first 28 days after birth) b. Infants between 12 : 24 months of age at the start of RSV season: i. Preterm infants who develop CLD/BPD of prematurity (defined as gestational age less than 32 weeks, 0 days AND a requirement for greater than 21% of oxygen for at least the first 28 days after birth) AND continue to require medical intervention (e.g., chronic corticosteroid therapy, diuretic therapy, supplemental oxygen) within the 6-month period before the start of the childs second RSV season 3. Hemodynamically significant Congenital Heart Disease (CHD) a. Infants younger than 24 months of age at the start of RSV season with one of the following: i. Acyanotic heart disease who are receiving medication to control congestive heart failure (CHF) AND will require cardiac surgical procedures ii. Cyanotic heart defects iii. Moderate to severe pulmonary hypertension iv. Will undergo cardiac transplantation during RSV season 4. Anatomic Pulmonary Abnormalities or Neuromuscular Disorder a. Infants younger than 12 months of age at the start of RSV season with a neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough/swallow 5. Immunocompromised status

PA Criteria	Criteria Details
	a. Infants younger than 24 months of age at the start of RSV season and are profoundly immunocompromised during the RSV season i. Examples of severe immunodeficiencies are: 1. Severe combined immunodeficiency 2. Severe acquired immunodeficiency syndrome 3. Acute myeloid leukemia / acute lymphoblastic leukemia 4. Chemotherapy 5. Solid organ or hematopoietic stem cell transplant recipients 6. Cystic Fibrosis: a. Infants younger than 12 months of age at the start of RSV season: i. With clinical evidence of CLD/BPD and/or nutritional compromise b. Infants between 12:24 months of age at the start of RSV season: i. For second year treatment, infant has manifestations of severe lung disease including one of the following: 1. Previous hospitalization for pulmonary exacerbation in the first year of life 2. Abnormalities on chest radiography or chest computed tomography that persist when stable 3. Weight for length less than the 10th percentile on a pediatric growth chart

PARICALCITOL

Products Affected

- *paricalcitol oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Hypercalcemia Vitamin D toxicity
Required Medical Information	SECONDARY HYPERPARATHYROIDISM INITIAL: Patients intact parathyroid hormone (iPTH) levels are greater than 240 pg/mL, corrected serum calcium less than 10.5 mg/dL, corrected serum Ca x (times) serum phosphorus less than 70 RENEWAL: (1) iPTH greater than 120 pg/mL (or 2 times the upper limit of normal) (2) Corrected serum calcium less than 11.5 mg/dL (3) Corrected serum Ca x (times) serum phosphorus less than 75
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	SECONDARY HYPERPARATHYROIDISM INITIAL Patient has a documented diagnosis of secondary hyperparathyroidism due to chronic kidney disease (CKD); AND Patients with CKD stage 5 are currently receiving hemodialysis (HD) or peritoneal dialysis (PD); AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to calcitriol or Hectorol oral or injection therapy by demonstrating iPTH level greater than 180 pg/mL; AND Patient development of hypercalcemia (serum calcium greater than 11.5 mg/dL) despite adequate therapy and discontinuance of calcium based phosphate binders.

PCSK9

Products Affected

- PRALUENT PEN
- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None

PA Criteria	Criteria Details
Required Medical Information	INITIAL: HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH): Patient has diagnosis of HeFH confirmed by [documentation req]: A. Simon Broome criteria: Prescriber reports total cholesterol greater than 290mg/dL or greater than 260mg/dL in patients less than 16 yrs, OR LDL cholesterol greater than 190mg/dL or greater than 155mg/dL in patients less than 16 yrs, AND B. History of tendon xanthomas in ONE of the following: (i) the patient, (ii) patients 1st degree relative (i.e. parent, sibling, or child), or (iii) patients 2nd degree relative (i.e. grandparent, uncle, or aunt) OR C. ONE of the following: (i) Family history of myocardial infarction (MI) in a 1st degree relative less than 60 yrs old, (ii) Family history of MI in a 2nd degree relative less than 50 yrs old, or (iii) Family history of LDL-C greater than 190mg/dL in a 1st or 2nd degree relative OR D. history of arcus cornealis before age of 45 in ONE of the following: (i) the patient or (ii) first or second degree relative B. HeFH diagnosis confirmed by genetic testing of an LDL receptor mutation, familiar defective apoB, or a PCSK9 mutation. HOMOZYGOUS FAMILIAL HYPERCHOLESTSEROLEMIA (HoFH): Clinical diagnosis confirmed ANY one the following: (i) Patient has a documented history of untreated LDL-C greater than 400 mg/dL and 1 or both parents have clinical diagnosed familial hypercholesterolemia (FH) or treated LDL-C greater than 300mg/dL (ii) Prescriber attests genetic evidence of a LDL receptor mutation, familial defective apo B-100, or a PCSK9 mutation or autosomal recessive FH or (iii) LDL-C greater than 400mg/dL with aortic valve disease or (v) LDL-C greater than 400mg/dL with xanthomata at less than 20 yrs of age. CLINICAL ASCVD OR PRIMARY HYPERLIPIDEMIA AT HIGH RISK FOR ASCVD:
	(1) Prescriber reports: baseline and current LDL-C, AND (2) One of the following: (a) baseline LDL-C is between 70-189mg/dL OR (b) patient requires greater than 25 percent additional lowering of LDL-C.

PA Criteria	Criteria Details
Age Restrictions	PRALUENT: CVD, HeFH, HoFH: 18 years of age or older. REPATHA: CVD: 18 years of age or older, HeFH and HoFH: 10 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	INITIAL: 12 months, RENEWAL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH): Prescriber attests that PCSK-9 will be used in combination with a maximally tolerated statin OR prescriber attests that member is statin intolerant and can provide rationale to intolerance or contraindication. HOMOZYGOUS FAMILIAL HYPERCHOLESTSEROLEMIA (HoFH): Prescriber attests that PCSK-9 will be used in combination with a maximally tolerated statin OR prescriber attests that member is statin intolerant and can provide rationale to intolerance or contraindication. CLINICAL ASCVD OR PRIMARY HYPERLIPIDEMIA AT HIGH RISK FOR ASCVD: (1a) Patient has a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) as defined as ONE of the following: a. History of or current acute coronary syndrome, b. myocardial infarction (MI), c. coronary or other arterial revascularization, d. stroke, e. transient ischemic stroke (TIA), f. stable/unstable angina, g. peripheral arterial disease presumed to be atherosclerotic region OR (1b) Patient is at high risk for ASCVD or CV event based on 10-year risk score use by ONE of the following tools: i. ASCVD pooled cohort risk assessment: score greater than or equal to 7.5 percent OR ii. Framingham Risk Score: score greater than or equal to 20 percent, AND (2) (a) Prescriber attests PCSK-9 will be used in combination with a maximally tolerated high-intensity statin OR (b) Prescriber attests that member is statin intolerant, as demonstrated by experiencing: i. Documented statin-associated rhabdomyolysis OR ii. Documented myositis or myalgia related symptoms with either, rosuvastatin, atorvastatin OR another maximally tolerated statin AND (3) Requires LDL-C reduction after at least a 90-day trial of BOTH of the following: (a) high-intensity statin (atorvastatin 40- 80mg OR rosuvastatin 20-40mg) or documentation of maximally tolerated statin

PA Criteria	Criteria Details
	AND (b) in combination with ezetimibe RENEWAL: ALL INDICATIONS: (1) Documented response, defined as ONE of the following: (a) Prescriber reports percentage reduction of LDL is greater than or equal to 40 percent compared to pre- PCSK-9 treatment OR (b) Prescriber reports absolute LDL is less than 70 mg/dL AND (2) Patient is tolerating the medication AND (3) Patient will continue to be used in combination with a maximally tolerated statin or is statin intolerant demonstrated by experiencing (a) Documented statin-associated rhabdomyolysis OR (b) Documented myositis or myalgia related symptoms with either, rosuvastatin, atorvastatin OR another maximally tolerated statin.

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: Documented confirmatory PAH diagnosis based on right heart catheterization with the following parameters: 1) Mean pulmonary artery pressure (PAP) of greater than 20 mmHg, 2) Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg, and 3) Pulmonary vascular resistance (PVR) greater than or equal to 3 Wood units
Age Restrictions	REVATIO/SILDENAFIL: 18 years of age or older.
Prescriber Restrictions	Prescribed by or given in consultation with a cardiologist or pulmonologist
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	INITIAL: (1) Has NYHA-WHO Functional Class II to IV symptoms, (2) Not concurrently or intermittently taking oral erectile dysfunction agents (e.g. Cialis, Viagra) or any organic nitrates in any form, and (3) Not concurrently taking guanylate cyclase stimulators (e.g. Adempas). RENEWAL: One of the following: 1) Improvement from baseline in the 6-minute walk distance test OR 2) Stable 6-minute walk distance test with a stable or improved World Health Organization functional class.

PEGFILGRASTIM

Products Affected

- NYVEPRIA
- ZIEXTENZO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist
Coverage Duration	12 months
Other Criteria	NEULASTA, FULPHILA, UDENYCA, ZIEXTENZO: Trial of or contraindication to Nyvepria where indications align. NEULASTA ONPRO: Patient has barrier to access (e.g., travel barriers, or patient is unable to return to clinic for Neulasta injections)

PEGINTERFERON ALFA 2A OR 2B (PEGASYS OR PEGINTRON)

Products Affected

- PEGASYS SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL: HEPATITIS B: Cirrhosis
Required Medical Information	INITIAL: HEPATITIS B: (1) Serum HBeAg positive chronic hepatitis B, AND (2) Evidence of viral replication with elevated serum ALT. HEPATITIS C: Detectable pretreatment HCV RNA level/viral load (Varies by lab assay but is a level typically greater than or equal to 25 IU/mL)
Age Restrictions	HEPATITIS B: 3 years of age or older HEPATITIS C: 3 to 11 years of age
Prescriber Restrictions	HEPATITIS B: Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, a physician specializing in the treatment of hepatitis (e.g., a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model. HEPATITS C: Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, or a physician specializing in the treatment of hepatitis (e.g., a hepatologist)
Coverage Duration	INIT/RNWL: HEP B: 24 wk; HEP C: GT 2 or 3: max tot of 24 wk. GT 1, 4, 5, 6: tot of 48 wk

PA Criteria	Criteria Details
Other Criteria	INITIAL: HEPATITIS B: Request is for Pegasys vial, kit, or syringes. HEPATITIS C: (1) Extrahepatic manifestations of hepatitis C such as cryoglobulinemia, rashes, and glomerulonephritis - as well as advanced fibrosis that requires urgent HCV treatment to minimize future morbidity and mortality, AND (2) Use with ribavirin or has a contraindication to ribavirin. RENEWAL: HEPATITIS B: Request is for Pegasys HEPATITIS C: (1) Request is for PegIntron, AND (2) Requested medication is being used with ribavirin or has a contraindication to combination therapy with ribavirin

PEMETREXED

Products Affected

- ALIMTA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	History of severe hypersensitivity reaction to pemetrexed. Diagnosis of squamous cell non-small cell lung cancer.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	A. Non-Squamous Non-Small Cell Lung Cancer: Patient has a diagnosis of Non-Squamous Non-Small Cell Lung Cancer; AND Used as a single agent after prior chemotherapy with 4 cycles of platinum-based first line chemotherapy; OR Used in combination with pembrolizumab and platinum chemotherapy, for initial treatment of patients with metastatic non-squamous NSCLC, with no EGFR or ALK genomic tumor aberrations; OR Used in combination with cisplatin/carboplatin for the initial treatment of patients with locally advanced or metastatic, non-squamous, non-small cell lung cancer. B. Malignant mesothelioma: Patient has a diagnosis of malignant mesothelioma; AND Patients disease is unresectable or patient is not a candidate for curative surgery; AND Used in combination with cisplatin or carboplatin.

PENICILLAMINE

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: WILSONS DISEASE: One of the following: (1) Plasma copper-protein ceruloplasmin less than 20mg/dL, (2) Liver biopsy positive for abnormally high amount of copper (greater than 250 mcg/d dry weight) or presence of Kayser-Fleischer rings, OR (3) Diagnosis confirmed by genetic testing for ATP7B mutations CYSTINURIA: Daily cystine output greater than 300mg per 24 hours following urine cystine excretion testing RENEWAL: WILSONS DISEASE: Free serum copper level less than 10 mcg/dL CYSTINURIA: Cystine excretion of less than 200 mg/day
Age Restrictions	None
Prescriber Restrictions	WILSONS DISEASE: Prescribed by or given in consultation with a hepatologist CYSTINURIA: Prescribed by or given in consultation with a nephrologist RHEUMTATOID ARTHRITIS (RA): Prescribed by or given in consultation with a rheumatologist
Coverage Duration	INITIAL: 12 months RENEWAL: Lifetime

PA Criteria	Criteria Details
Other Criteria	INITIAL: Request for D-Penamine may be approved without additional criteria met if patient has an active prior authorization approval for Depen: [Note: D-Penamine is temporarily available to address a critical drug shortage of Depen. Patients previously approved for Depen will be allowed access without additional criteria during this shortage.] WILSONS DISEASE: (1) Maintained a low copper diet (less than 2 mg copper per day). (2) Requests for Cuprimine require trial of or contraindication to Depen (penicillamine) or D-Penamine (penicillamine) CYSTINURIA: (1) Presence of nephrolithiasis and one of the following: (a) Stone analysis positive for cystine, (b) Urinalysis positive for pathognomonic hexagonal cystine crystals, (c) Family history of cystinuria with positive cyanide-nitroprusside screen. (2) Failure to respond to an adequate trial of or contraindication to all of the following conventional therapies: increased fluid intake, modest reductions in sodium and protein intake, and urinary alkalinization. (3) Requests for Cuprimine require trial of or contraindication to Depen (penicillamine) or D-Penamine (penicillamine) AND Thiola (tiopronin) RA: (1) No history of or other evidence of renal insufficiency, (2) Failure to respond to an adequate trial of at least 3 months of conventional therapy including at least ONE of the following DMARD (disease-modifying antirheumatic drug) agents: methotrexate dose greater than or equal to 20mg per week or maximally tolerated dose, leflunomide, hydroxychloroquine, or sulfasalazine. (3) Requests for Cuprimine require trial of or contraindication to Depen or D-Penamine
	RENEWAL: RA: 1) No history of or other evidence of renal insufficiency 2) Experienced or maintained improvement in tender joint count or swollen joint count while on therapy compared to baseline

PENTOSAN POLYSULFATE

Products Affected

- ELMIRON

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	INITIAL: 6 months. RENEWAL: Lifetime IL: Initial: 12 months Renewal: Lifetime
Other Criteria	INITIAL: Interstitial cystitis/bladder pain syndrome ongoing for at least six weeks. RENEWAL: Clinical improvement from baseline secondary to treatment

PHENOXYBENZAMINE

Products Affected

- *phenoxybenzamine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, an endocrine surgeon, or a hematologist/oncologist
Coverage Duration	21 days
Other Criteria	(1) Requested for treatment of pheochromocytoma prior to pheochromocytoma resection/removal. (2) Trial of or contraindication to an alpha-1 selective adrenergic receptor blocker (such as doxazosin, terazosin, or prazosin).

PHOSPHATE BINDERS

Products Affected

- *sevelamer carbonate oral powder in packet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Sevelamer carbonate/sevelamer HCl/lanthanum carbonate: Patients with bowel obstruction. Sevelamer carbonate ONLY: Patients with known hypersensitivity to sevelamer carbonate or sevelamer hydrochloride.
Required Medical Information	None
Age Restrictions	Sevelamer carbonate: 6 years of age and older. All others: 18 years of age and older.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For sevelamer carbonate powder packet/sevelamer HCL/Velphoro: patient has a diagnosis of chronic kidney disease (CKD); AND Patient is on dialysis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to sevelamer carbonate tablets. For lanthanum carbonate: patient has a diagnosis of end-stage renal disease (ESRD); AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to sevelamer carbonate tablets.

PIRFENIDONE

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 801 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: (1) Usual interstitial pneumonia (UIP) pattern as evidenced by high-resolution computed tomography (HRCT) alone or via a combination of surgical lung biopsy and HRCT. (2) Predicted forced vital capacity (FVC) of at least 50% at baseline
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	INTIAL: (1) No other known causes of interstitial lung disease (e.g., connective tissue disease, drug toxicity, asbestos or beryllium exposure, hypersensitivity pneumonitis, systemic sclerosis, rheumatoid arthritis, radiation, sarcoidosis, bronchiolitis obliterans organizing pneumonia, human immunodeficiency virus (HIV) infection, viral hepatitis, or cancer). (2) Patient does not currently smoke cigarettes. RENEWAL: Clinically meaningful improvement or maintenance in annual rate of decline

PKU

Products Affected

- MSUD EXPRESS15
- PHENYLADE 40
- PHENYLADE AMINO ACIDS
- PHENYLADE MTE AMINO ACIDS
- PKU AIR20
- PKU COOLER 10
- PKU COOLER 15
- PKU COOLER 20
- PKU EXPRESS15
- PKU EXPRESS20
- PKU GEL POWDER
- PKU GO
- PKU SPHERE15
- PKU SPHERE20 ORAL POWDER IN PACKET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	Male: 21 years of age or younger, Female: 35 years of age or younger
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	PHENYLKETONURIA (1) Patient has diagnosis of Phenylketonuria

POMALIDOMIDE

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

PRAZIQUANTEL

Products Affected

- *praziquantel*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with ocular cysticercosis. Patients taking strong Cytochrome P450 (CYP450) inducers, such as rifampin.
Required Medical Information	None
Age Restrictions	1 year of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	7 days.
Other Criteria	Patient has a documented diagnosis of Schistosomiasis due to a species of schistosoma (for example, Schistosoma mekongi, Schistosoma japonicum, Schistosoma mansoni and Schistosoma hematobium); OR Patient has a documented diagnosis of Clonorchiasis or Opisthorchiasis due to the liver flukes, Clonorchis sinensis/Opisthorchis viverrini.

PYRAZINAMIDE

Products Affected

- *pyrazinamide*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with severe hepatic damage Patients with acute gout
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, an Infectious Disease specialist
Coverage Duration	2 months
Other Criteria	Patient has a documented diagnosis of active tuberculosis; AND pyrazinamide will be used in combination with other antituberculous agents; AND prescribed dosing and duration are within the current CDC and American Thoracic Society guidelines

PYRIDOSTIGMINE

Products Affected

- *pyridostigmine bromide oral syrup*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Mechanical intestinal or urinary obstruction
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of myasthenia gravis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to pyridostigmine oral tablets.

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Covered Uses	Toxoplasmosis (Treatment and prophylaxis). Pneumocystis Pneumonia (primary and secondary prophylaxis).
Exclusion Criteria	Patients with documented megaloblastic anemia due to folate deficiency
Required Medical Information	TOXOPLASMOSIS Chart notes/medical records required for all of the below. PRIMARY PROPHYLAXIS FOR TOXOPLASMIC ENCEPHALITIS: (1a) patient is Toxoplasma IgG positive; AND (1b) Patient has a documented CD4 less than or equal to 100 cells/mm3 if initiating prophylaxis OR CD4 less than 100-200 cells/mm3 if reinstituting prophylaxis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	PRIMARY PROPHYLAXIS: 6 mo. TREATMENT AND SECONDARY PROPHYLAXIS: 12 mo.

PA Criteria	Criteria Details
Other Criteria	TOXOPLASMOSIS Chart notes/medical records required for all of the below. (1) Patient has a documented diagnosis of active severe acquired toxoplasmosis (including toxoplasmic encephalitis and congenital toxoplasmosis); OR (2) Pyrimethamine is being used for secondary prophylaxis of toxoplasmic encephalitis; OR (3) Pyrimethamine is being used for primary prophylaxis for toxoplasmic encephalitis; AND 3a) pyrimethamine will be used in combination with dapsone or atovaquone; AND 3b) Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP- SMX); AND 3c) Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate; OR 3d) Patient has experienced a moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g. toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome). PNEUMOCYSTIS PNEUMONIA (PCP) (1a) Pyrimethamine is being used as primary Pneumocystis Pneumonia (PCP) prophylaxis in an HIV infected patient; OR (1b) pyrimethamine is being used as secondary prophylaxis in an HIV infected patient who has been treated for an acute episode of Pneumocystis Pneumonia; AND (2) Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP- SMX); AND (3a) Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate; OR (3b) Patient has experienced a moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g. toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome).

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications. Xifaxan 200mg: Hepatic encephalopathy (HE), Clostridium difficile infection (CDI)
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	HEPATIC ENCEPHALOPATHY: Xifaxan 550mg: 18 years of age or older. IRRITABLE BOWEL SYNDROME WITH DIARRHEA: 18 years of age or older TRAVELERS DIARRHEA: 12 years of age or older
Prescriber Restrictions	HEPATIC ENCEPHALOPATHY: Prescribed by or in consultation with a hepatologist. IRRITABLE BOWEL SYNDROME WITH DIARRHEA: Prescribed by or in consultation with a gastroenterologist. CLOSTRIDIUM DIFFICILE INFECTION: Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	INIT: HE: 550mg: 12 m; 200mg: 10 d IBS: 12 w TRVLRS DIARR: 3 d C.DIFF: 20 d RNWL: HE, IBS: 12 m

PA Criteria	Criteria Details
Other Criteria	INITIAL: HEPATIC ENCEPHALOPATHY: One of the following: 1) Trial of lactulose or currently on lactulose monotherapy AND request is for Xifaxan 550mg tablets, OR 2) Concurrent use with lactulose AND request is for Xifaxan 200mg tablets. IRRITABLE BOWEL SYNDROME WITH DIARRHEA: (1) Trial of or contraindication to tricyclic anti-depressants or dicyclomine, AND (2) Request is for Xifaxan 550mg tablets. TRAVELERS DIARRHEA: (1) Trial of or contraindication to oral azithromycin, ciprofloxacin, ofloxacin, or levofloxacin, AND (2) Request is for Xifaxan 200mg tablets. CLOSTRIDIUM DIFFICILE INFECTION: (1) Had at least one previous occurrence of Clostridium difficile infection, AND (2) Use in combination with vancomycin. RENEWAL: HEPATIC ENCEPHALOPATHY: Request is for Xifaxan 550mg tablets. IRRITABLE BOWEL SYNDROME WITH DIARRHEA: 1) At least 10 weeks have passed since the last treatment course of rifaximin AND 2) Patient has experienced at least 30% decrease in abdominal pain (on a 0-10 point pain scale), AND 3) Patient has experienced at least 50% reduction in the number of days per week with a stool consistency of mushy stool (Bristol Stool scale type 6) or entirely liquid stool (Bristol Stool scale type 7) AND 4) Request is for Xifaxan 550mg tablets

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INIT. 6 mo, RENWL: 12 mo. IL: Initial Acute Migraine Tx: 6 mo, all others: 12 mo

PA Criteria	Criteria Details
Other Criteria	INITIAL: ACUTE MIGRAINE TREATMENT: Trial of or contraindication to ONE triptan (e.g., sumatriptan, rizatriptan). EPISODIC MIGRAINE PREVENTION: 1) Trial of or contraindication to ONE preventive migraine treatment (e.g., divalproex sodium/sodium valproate, topiramate, propranolol, timolol, metoprolol, amitriptyline, venlafaxine, atenolol, nadolol), 2) Trial of or contraindication to the preferred agents: Emgality AND Aimovig unless the patient has needle phobia, dexterity issue, or other reason they cannot use an injectable CGRP inhibitor. RENEWAL: ACUTE MIGRAINE TREATMENT: 1) Improvement from baseline in a validated acute treatment patient-reported outcome questionnaire OR 2) Clinical improvement as defined by ONE of the following: a) Ability to function normally within 2 hours of dose, b) Headache pain disappears within 2 hours of dose, or c) Therapy works consistently in majority of migraine attacks. EPISODIC MIGRAINE PREVENTION: 1) Reduction in migraine or headache frequency of at least 2 days per month, OR 2) Reduction in migraine severity or migraine duration.

RIOCIGUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH) WHO GROUP I: INITIAL: Confirmatory diagnosis based on right heart catheterization with the following parameters: 1) Mean pulmonary artery pressure (PAP) greater than 20 mmHg, 2) Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg, 3) Pulmonary vascular resistance (PVR) greater than or equal to 3 Wood units. NYHA-WHO functional class II-IV symptoms. CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4: INITIAL: NYHA-WHO functional class II-IV Symptoms.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: PAH: Not concurrently taking nitrate or nitric oxide donors, phosphodiesterase inhibitors, or non-specific phosphodiesterase inhibitors. CTEPH: (1) Not concurrently taking nitrate or nitric oxide donors, phosphodiesterase inhibitors, or non-specific phosphodiesterase inhibitors. (2) Patient has persistent or recurrent disease after surgical treatment OR is not a candidate for surgery or has inoperable CTEPH. RENEWAL: PAH/CTEPH: (1) Improvement from baseline in the 6-minute walk distance, OR (2) Stable 6-minute walk distance and a stable or improved World Health Organization (WHO) functional class.

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	PsO: Prescribed by or in consultation with a dermatologist. PsA: Prescribed by or in consultation with a rheumatologist or dermatologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months IL: 12 months
Other Criteria	INITIAL: PsO: Psoriasis covering 3% or more of body surface area or psoriatic lesions affecting the hands, feet, genital area, or face. Previous trial of or contraindication at least one conventional therapy such as a PUVA (phototherapy ultraviolet light a), UVB (ultraviolet light b), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. PsA: trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine RENEWAL: PsO: Achieved or maintained clear or minimal disease, OR a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more while on therapy. PsA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy

ROTIGOTINE

Products Affected

- NEUPRO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of Parkinsons disease OR restless leg syndrome; AND one of the following: 1) Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic oral pramipexole AND oral ropinirole; OR 2) Patient is unable to ingest solid oral dosage forms due to one of the following: Oral/motor difficulties; OR Dysphagia.

SECUKINUMAB

Products Affected

- COSENTYX
- COSENTYX (2 SYRINGES)
- COSENTYX PEN
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (nr-axSpA): ONE of the following objective signs of inflammation: (1) C-reactive protein (CRP) levels above the upper limit of normal OR (2) Sacroiliitis on magnetic resonance imaging (MRI)
Age Restrictions	PLAQUE PSORIASIS (PsO): 6 years of age or older PSORIATIC ARTHRITIS (PsA): 2 years of age or older ANKYLOSING SPONDYLITIS (AS), NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (nr-axSpA): 18 years of age or older ENTHESITIS-RELATED ARTHRITIS (ERA): 4 years of age or older
Prescriber Restrictions	PsO: Prescribed by or in consultation with a dermatologist. PsA: Prescribed by or in consultation with a rheumatologist or dermatologist AS/nr-axSpA, ERA: Prescribed by or in consultation with a rheumatologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: PsO: Moderate to severe plaque psoriasis covering 3% or more of body surface area or psoriatic lesions affecting the hands, feet, genital area, or face. Trial of or contraindication to at least one conventional therapy such as a PUVA (phototherapy ultraviolet light a), UVB (ultraviolet light b), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. PsA: (1) Trial of or contraindication to one DMARD (disease-modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. (2) Request of 300mg dosing schedule requires trial of 150mg dosing schedule AND patient continue to have active psoriatic arthritis AS: (1) Trial of or contraindication to an NSAID (e.g., ibuprofen, naproxen, meloxicam, diclofenac, etc.). (2) Request of 300mg dosing schedule requires trial of 150mg dosing schedule AND patient continue to have active psoriatic arthritis. nr-axSpA: Trial of or contraindication to an NSAID (e.g., ibuprofen, naproxen, meloxicam, diclofenac, etc.) ERA: Trial of or contraindication to an NSAID (e.g., ibuprofen, naproxen, meloxicam, diclofenac, etc.), sulfasalazine, OR methotrexate RENEWAL: PsO: Patient achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more while on therapy. PsA: Patient experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. AS/nr-axSpA: Patient experienced or maintained an improvement of at least 50% or 2 units (scale of 1 - 10) in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) while on therapy ERA: Patient has experienced or maintained an improvement in global assessment of disease activity, functional ability, number of
	joints with active arthritis, OR number of joints with limited range of motion

SIROLIMUS

Products Affected

- *sirolimus*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	LYMPHANGIOLEIOMYOMATOSIS (LAM): Prescriber attests patient has diagnosis of Lymphangioleiomyomatosis (LAM) confirmed by lung biopsy or HRCT showing cystic lung disease
Age Restrictions	LAM: 18 years of age or older
Prescriber Restrictions	RENAL TRANSPLANT: Prescribed by or in consultation with a transplant specialist. LAM: Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	12 months
Other Criteria	PROPHYLAXIS OF ORGAN REJECTION IN RENAL TRANSPLANTS: The patient has had a trial and failure on an anti-rejection regimen containing at least two (2) of the following: (a) cyclosporine (b) tacrolimus (c) azathioprine (d) mycophenolate mofetil/sodium LYMPHANGIOLEIOMYOMATOSIS (LAM): Patient has one of the following conditions: (i) Diagnosis of Tuberous Sclerosis Complex (TSC) (ii) Chylous Pleural Effusion (iii) Angioleiomyoma

SOFOSBUVIR/VELPATASVIR

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	(1) Currently taking any of the following medications: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, efavirenz-containing HIV regimens, rosuvastatin at doses above 10mg, tipranavir/ritonavir or topotecan. (2) Has a limited life expectancy (less than 12 months) due to non-liver related comorbid conditions.
Required Medical Information	Chronic HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months
Age Restrictions	3 years of age or older
Prescriber Restrictions	Currently supervised by a gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (for example, a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model
Coverage Duration	Coverage duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	(1) Currently taking any of the following medications: amiodarone, rifampin, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifapentine, HIV regimen containing atazanavir, lopinavir, tipranavir/ritonavir, or efavirenz, rosuvastatin, pitavastatin, pravastatin (at doses above 40mg), cyclosporine, methotrexate, mitoxantrone, imatinib, irinotecan, lapatinib, sulfasalazine, or topotecan. (2) Moderate to severe hepatitis impairment (Child-Pug B or C). (3) Has limited life expectancy (less than 12 months) due to non-liver related comorbid conditions.
Required Medical Information	Current HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months
Age Restrictions	18 years of age or older
Prescriber Restrictions	Currently supervised by a gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (for example, a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model
Coverage Duration	Coverage duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

SORAFENIB

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SUCRALFATE

Products Affected

- *sucralfate oral suspension*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypersensitivity to sucralfate
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist
Coverage Duration	3 months. IL: 12 months
Other Criteria	Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic oral sucralfate tablet.

SUMATRIPTAN

Products Affected

- *sumatriptan nasal spray,non-aerosol 20 mg/actuation, 5 mg/actuation*
- *sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml*
- *sumatriptan succinate subcutaneous solution*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Prevention of migraine or cluster headache attacks. Nasal Spray: treatment of cluster headache Ischemic coronary artery disease (CAD) (angina pectoris, history of myocardial infarction, or documented silent ischemia) or coronary artery vasospasm, including Prinzmetals angina. Wolff-Parkinson-White syndrome or arrhythmias associated with other cardiac accessory conduction pathway disorders. History of stroke or transient ischemic attack (TIA) or history of hemiplegic or basilar migraine because these patients are at a higher risk of stroke. Peripheral vascular disease. Ischemic bowel disease. Uncontrolled hypertension. Recent use (i.e., within 24 hours) of ergotamine-containing medication, ergot-type medication (such as dihydroergotamine or methysergide), or another 5-hydroxytryptamine1 (5-HT1) agonist. Concurrent administration of a monoamine oxidase (MAO)-A inhibitor or recent (within 2 weeks) use of an MAO-A inhibitor. Hypersensitivity to sumatriptan. Severe hepatic impairment.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	ACUTE TREATMENT OF MIGRAINES: Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to ALL of the following (medication usage must be supported by documentation from the patients chart notes/medical records electronic claim history): oral sumatriptan, rizatriptan, naratriptan, almotriptan; AND Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to Sumatriptan Nasal Spray (before injection).

SUNITINIB

Products Affected

- *sunitinib*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 year of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	GASTROINTESTINAL STROMAL TUMOR (GIST): Trial of or contraindication to imatinib mesylate (Gleevec)

TEMOZOLOMIDE - IV

Products Affected

- TEMODAR INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications. Metastatic Melanoma. Small cell lung cancer (SCLC).
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TEMOZOLOMIDE-PO

Products Affected

- *temozolomide*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications. Metastatic melanoma, small cell lung cancer (SCLC).
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TERIFLUNOMIDE

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TESTOSTERONE

Products Affected

- *methyltestosterone oral capsule gram)*
- *testosterone enanthate*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1.62 % (40.5 mg/2.5*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications. Gender dysphoria as supported by the compendia (e.g., DrugDex strength of recommendation Class I, IIa, or IIb)
Exclusion Criteria	None
Required Medical Information	INITIAL: MALE HYPOGONADISM: Low testosterone levels confirmed by at least ONE of the following laboratory values: 1) Two morning total serum testosterone levels of less than 300 ng/dL (10.4 nmol/L) taken on separate occasions while in a fasted state or 2) Free serum testosterone level of less than 5 pg/mL (0.17 nmol/L)
Age Restrictions	GENDER DYSPHORIA: 16 years of age or older ALL OTHER INDICATIONS: None
Prescriber Restrictions	None
Coverage Duration	INIT/RNWL: MALE HYPOGN, GENDER DYSPH: 12 mo. MALE DELAYD PBRTY, FEM METS. BRST CNCR: Lifetime

PA Criteria	Criteria Details
Other Criteria	INITIAL: MALE HYPOGONADISM: Testosterone levels not required for the following patients: 1) Has a previously approved prior authorization for testosterone, OR 2) Receiving any form of testosterone replacement therapy per physician attestation or claims history. ANDROID OR TESTRED REQUEST: Require a trial of or contraindication to TWO lower cost agents. DELAYED PUBERTY IN MALES NOT DUE TO A PATHOLOGICAL DISORDER or FEMALE WITH METASTATIC BREAST CANCER: Requests for methyltestosterone (Testred or Android) require a trial of or contraindication to intramuscular testosterone enanthate. RENEWAL: MALE HYPOGONADISM: (1) Improved symptoms compared to baseline and tolerance to treatment, AND (2) Documentation of normalized serum testosterone levels and hematocrit concentrations compared to baseline.

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Patients who are actively suicidal, or in patients with untreated or inadequately treated depression. Patients with hepatic impairment. Patients taking monoamine oxidase inhibitors (MAOIs) or within a minimum of 14 days of discontinuing therapy with an MAOI. Concomitant therapy with reserpine (at least 20 days should elapse after stopping reserpine before starting tetrabenazine. Concomitant therapy with deutetrabenazine or valbenazine.
Required Medical Information	INITIAL: Patients who require doses of XENAZINE greater than 50 mg/day should be first tested and genotyped to determine if they are poor metabolizers (PMs) or extensive metabolizers (EMs) by their ability to express the drug metabolizing enzyme, CYP2D6; AND Patient is a confirmed extensive metabolizer (poor metabolizer should not exceed a daily dose of 50mg).
Age Restrictions	None
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist that treats Huntingtons Disease
Coverage Duration	INITIAL/RENEWAL: 3 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: Patient has had a documented trial and therapeutic failure of at least TWO (2) of the following: amantadine, an antipsychotic (fluphenazine, haloperidol, risperidone, ziprasidone, quetiapine, or olanzapine), riluzole, a benzodiazepine. RENEWAL: (1) Signs and symptoms of chorea must be decreased (2) Adverse reactions such as akathisia, restlessness, parkinsonism, depression, insomnia, anxiety, or sedation occur have not subsided with dose reduction.

TEZACAFTOR/IVACAFTOR

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: (1) Documentation that patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene, OR (2) Documentation that patient has at least one mutation in the CFTR gene.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cystic fibrosis expert
Coverage Duration	INITIAL: 24 weeks. RENEWAL: Lifetime. IL: Initial: 12 months Renewal: Lifetime
Other Criteria	RENEWAL: Improvement in clinical status compared to baseline as shown by Improved, maintained, or demonstrated less than expected decline in ONE of the following: FEV1, or body mass index (BMI), or reduction in rate of pulmonary exacerbations.

THALIDOMIDE

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications. Anemia due to myelodysplastic syndrome. Waldenstroms Macroglobulinemia.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	MULTIPLE MYELOMA: Use in combination with dexamethasone or prednisone. ANEMIA DUE TO MYELODYSPLASTIC SYNDROME: Patient have been previously treated.

THIOGUANINE

Products Affected

- TABLOID

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients whose disease has demonstrated prior resistance to mercaptopurine and thioguanine. Use during maintenance therapy or similar long-term continuous treatments for acute nonlymphocytic leukemias. Treatment of chronic lymphocytic leukemia, Hodgkins lymphoma, multiple myeloma, or solid tumors.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	12 months
Other Criteria	None

TOBRAMYCIN INHALED

Products Affected

- *tobramycin in 0.225 % nacl*
- *tobramycin with nebulizer*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with a known hypersensitivity to any aminoglycoside. Patients with an FEV1 less than 25% or greater than 75% predicted Patients colonized with Burkholderia cepacia.
Required Medical Information	Patient has a documented diagnosis of lung infection due to Pseudomonas aeruginosa.
Age Restrictions	6 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months.
Other Criteria	None

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	RHEUMATOID ARTHRITIS (RA), PSORIATIC ARTHRITIS (PsA), ULCERATIVE COLITIS (UC), ANKYLOSING APONDYLITIS (AS) : 18 years of age or older POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (pcJIA): 2 years of age or older
Prescriber Restrictions	RA/pcJIA/AS: Prescribed by or in consultation with a rheumatologist PsA: Prescribed by or in consultation with a rheumatologist or dermatologist UC: Prescribed by or in consultation with a gastroenterologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: Trial of or contraindication to at least 3 months of treatment with ONE DMARD (disease-modifying antirheumatic drugs), such as methotrexate dose greater than or equal to 20mg per week or maximally tolerated dose, leflunomide, hydroxychloroquine, or sulfasalazine AND trial or contraindication to a tumor necrosis factor (TNF) blocker (e.g., Humira, Enbrel). PsA/pcJIA: Trial of or contraindication to ONE DMARD such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine AND trial or contraindication to a TNF blocker (e.g., Humira, Enbrel). AS: Trial of or contraindication to an NSAID (e.g., ibuprofen, naproxen, meloxicam, diclofenac, etc.) AND Trial or contraindication to a tumor necrosis factor (TNF) blocker (e.g., Humira, Enbrel). UC: Trial of or contraindication to ONE standard therapy, such as corticosteroids (i.e., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine, AND Trial of or contraindication to a TNF blocker: Humira. [NOTE: Pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify] RENEWAL: RA/PsA/pcJIA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. AS: Patient has experienced or maintained an improvement of at least 50% or 2 units (scale of 1-10) in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score while on therapy. UC: Diagnosis of moderate to severe UC.

TOREMIFENE

Products Affected

- *toremifene*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TREPROSTINIL

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	ORENITRAM: Severe hepatic impairment
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH) (WHO GROUP 1): Documented confirmatory PAH diagnosis based on right heart catheterization with the following parameters: (1) Mean pulmonary artery pressure (PAP) of greater than 20 mmHg, (2) Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg, (3) Pulmonary vascular resistance (PVR) greater than or equal to 3 Wood units (WU) TYVASO ONLY: PULMONARY HYPERTENSION (PH) (WHO Group 3): Diagnosis confirmed based on right heart catheterization with the following parameters: (1) Pulmonary vascular resistance (PVR) greater than or equal to 3 WU, (2) Mean pulmonary artery pressure (PAP) of greater than 20 mmHg, (3) Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
Age Restrictions	None
Prescriber Restrictions	Prescribed by or given in consultation with a cardiologist or pulmonologist
Coverage Duration	INIT: REMODULIN/ORENITRAM, TYVASO PAH: 12 mo. TYVASO PH G3: INIT: 6 mo. RNWL: All: 12 mo. IL: 12 mo

PA Criteria	Criteria Details
Other Criteria	INITIAL: REMODULIN 1 of the following: (1) Cont. of Remodulin (treprostinil) therapy from hospital discharge AND patient has NYHA/WHO FC II, III, or IV symptoms OR (2) New request for Remodulin AND patient has NYHA-WHO FC III or IV symptoms OR (3) New request for Remodulin AND patient has NYHA-WHO FC II symptoms AND trial of or contraindication to TWO of the following from different drug classes: a) oral endothelin receptor antagonist (e.g., ambrisentan, bosentan, or macitentan), b) oral phosphodiesterase-5 inhibitor (e.g., sildenafil or tadalafil), c) oral cGMP inhibitor (e.g., riociguat) TYVASO PAH WHO GROUP 1: (1) NYHA-WHO FC III or IV symptoms. (2) One of the following: (a) WHO FC III symptoms AND trial of or contraindication to TWO of the following agents from different drug class: (i) oral endothelin receptor antagonist (e.g., ambrisentan, bosentan, or macitentan), (ii) oral phosphodiesterase-5 inhibitor (e.g., sildenafil or tadalafil), (iii) oral cGMP inhibitor (e.g., riociguat) OR (b) WHO FC III symptoms with evidence of rapid progression/poor prognosis, or WHO FC IV symptoms AND trial of or contraindication to ONE IV/SQ prostacyclin (e.g., epoprostenol or treprostinil) ORENITRAM One of the following: (1) Continuation of Orenitram (treprostinil) therapy from hospital discharge AND NYHA/WHO FC II, III, or IV symptoms OR (2) New start of Orenitram AND WHO FC II or III symptoms AND trial of or contrainidication to TWO of the following agents from different drug classes: (a) oral endothelin receptor antagonist (e.g.,

PA Criteria	Criteria Details
	ambrisentan, bosentan, or macitentan), (b) oral phosphodiesterase-5 inhibitor (e.g., sildenafil or tadalafil), (c) oral cGMP inhibitor (e.g., riociguat), AND trial of or contraindication to the preferred oral prostanoid: Uptravi. OR (3) New start of Orenitram AND WHO FC III symptoms with evidence of rapid progression/poor prognosis, or WHO FC IV symptoms AND trial of or contraindication to ONE IV/SQ prostacycline (e.g., epoprostenol or treprostinil) AND trial of or contraindication to the preferred oral prostanoid: Uptravi RENEWAL: REMODULIN / ORENITRAM: One of the following: (1) Patient had improvement from baseline in the 6-minute walk distance test OR (2) Patient remained stable from baseline in the 6-minute walk distance test AND the patients World Health Organization (WHO) functional class has improved or remained stable TYVASO: PAH WHO GROUP 1: One of the following: (1) Patient had improvement from baseline in the 6-minute walk distance test OR (2) Patient remained stable from baseline in the 6-minute walk distance test AND the patients World Health Organization (WHO) functional class has improved or remained stable PH WHO GROUP 3: One of the following: (1) Patient had improvement from baseline in the 6-minute walk distance test OR (2) Patient has stable 6-minute walk distance test

TRETINOIN ORAL

Products Affected

- *tretinoin (antineoplastic)*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with known hypersensitivity to tretinoin or other retinoids.
Required Medical Information	Patient has a documented diagnosis of acute promyelocytic leukemia (APL), French-American-British (FAB) classification M3 (including the M3 variant) confirmed by the presence of the t(15;17) translocation AND/OR the presence of the PML/RAR gene.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	12 months
Other Criteria	Tretinoin will be used for the induction of remission only; AND Patient is refractory to, or has relapsed from, anthracycline chemotherapy, or anthracycline-based chemotherapy is contraindicated; Patient will receive an accepted form of remission consolidation and/or maintenance therapy for APL after completion of induction therapy with tretinoin.

TRIAMCINOLONE AEROSOL

Products Affected

- *triamcinolone acetonide topical aerosol*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to at least THREE of the following: mometasone 0.1% solution, fluocinonide 0.05% solution, fluocinolone 0.01% solution, clobetasol 0.05% shampoo, clobetasol 0.05% solution

TRIFLURIDINE EYE DROPS

Products Affected

- *trifluridine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	21 Days
Other Criteria	Patient has diagnosis of primary keratoconjunctivitis or recurrent epithelial keratitis due to herpes simplex virus, types 1 or 2.

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months.
Other Criteria	INITIAL: Trial of or contraindication to ONE triptan. RENEWAL: 1) Improvement from baseline in a validated acute treatment patient-reported outcome questionnaire (e.g., Migraine Assessment of Current Therapy [Migraine-ACT]), OR 2) Clinical improvement as defined by ONE of the following: a) ability to function normally within 2 hours of dose, b) headache pain disappears within 2 hours of dose, or c) therapy works consistently in majority of migraine attacks

UPADACITINIB

Products Affected

- RINVOQ

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	RA/PSA/UC: 18 years of age or older AD: 12 years of age or older
Prescriber Restrictions	RA: Prescribed by or in consultation with a rheumatologist PSA: Prescribed by or in consultation with a rheumatologist or dermatologist AD: Prescribed by or in consultation with a dermatologist, allergist, or immunologist
Coverage Duration	INITIAL: RA/PSA: 6 months. AD: 4 months. UC: 12 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: Rheumatoid Arthritis (RA):Trial of or contraindication to at least 3 months of treatment with ONE DMARD (disease-modifying antirheumatic drugs), such as methotrexate dose greater than or equal to 20mg per week or maximally tolerated dose, leflunomide, hydroxychloroquine, or sulfasalazine AND a trial of or contraindication to a tumor necrosis factor (TNF) blocker: Humira or Enbrel. Psoriatic Arthritis (PSA): A trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine AND a trial of or contraindication to a tumor necrosis factor (TNF) blocker: Humira or Enbrel. Moderate to severe Atopic Dermatitis (AD): Trial of a high or super-high potency topical corticosteroid (e.g., triamcinolone acetonide, fluocinonide, clobetasol propionate, halobetasol propionate) OR one non-steroidal topical immunomodulating agent (e.g., Eucrisa, pimecrolimus, tacrolimus). Moderate to severe Ulcerative Colitis (UC): The patient has had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blockers (e.g., Humira, Remicade, Simponi SQ). RENEWAL: RA/PSA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. AD: Patient has experienced or maintained improvement in at least two of the following: intractable pruritus, cracking and oozing/bleeding of affected skin, impaired activities of daily living.

USTEKINUMAB

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	PLAQUE PSORIASIS (PsO): 6 years of age or older PSORIATIC ARTHRITIS (PsA), CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): 18 years of age or older
Prescriber Restrictions	PsO: prescribed by or in consultation with a dermatologist PsA: prescribed by or in consultation with a rheumatologist or dermatologist CD/UC: prescribed by or in consultation with a gastroenterologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: PsO: (1) Psoriasis covering 3% or more of body surface area or psoriatic lesions affecting the hands, feet, genital area, or face. (2) Trial of or contraindication at least one standard therapy such as a PUVA (phototherapy ultraviolet light a), UVB (ultraviolet light b), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. (3) Documentation of patients weight. PsA: Trial of or contraindication to one DMARD (disease-modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. CD/UC: (1) Trial of or contraindication to at least one standard therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. RENEWAL: PsA WITHOUT PsO: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. PsO: (1) Achieved or maintained clear or minimal disease, OR a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more. (2) Documentation of patients current weight.

VALGANCICLOVIR

Products Affected

- *valganciclovir oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypersensitivity to valganciclovir or ganciclovir.
Required Medical Information	PREVENTION OF CMV DISEASE Donor CMV seropositive/Recipient CMV seronegative [D+/R-]
Age Restrictions	Pediatric kidney transplant: 4 months of age and older Pediatric heart transplant: 1 month of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	CYTOMEGALOVIRUS (CMV) RETINITIS: Patient has a documented diagnosis of Cytomegalovirus (CMV) Retinitis; AND Patients has a documented diagnosis of acquired immunodeficiency syndrome (AIDS). PREVENTION OF CMV DISEASE: The patient is at high risk for CMV, the donor is CMV seropositive, and recipient is CMV seronegative [D+/R-] AND patients meets ONE of the following: (1) the patient is post kidney transplant and is 4 months of age or older, (2) the patient is post heart transplant and is 1 month of age or older, or (3) the patient is post kidney-pancreas transplant. NOTE: Requests for oral solution require a history of trial and failure, contraindication, or intolerance to oral valganciclovir tablets OR a documented inability to ingest solid oral dosage forms.

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications OR for continuation of therapy if patient is stable on requested medication.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

VORICONAZOLE

Products Affected

- *voriconazole oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Coadministration of cisapride, pimozide, quinidine, ivabradine, Sirolimus, rifampin, carbamazepine, and long-acting barbiturates, efavirenz doses of 400 mg every 24 hours or higher, ritonavir, rifabutin, ergot alkaloids (ergotamine and dihydroergotamine), St. Johns Wort, naloxegol, tolvaptan, venetoclax (at initiation and during the ramp-up phase).
Required Medical Information	Fungal culture and other relevant laboratory studies (including histopathology) need to be obtained to isolate and identify causative organisms
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	12 months
Other Criteria	TREATMENT OF INVASIVE ASPERGILLUS Patient has a diagnosis of clinically documented invasive aspergillosis, that is susceptible to voriconazole confirmed by fungal culture and other relevant laboratory studies (including histopathology) with isolated and identified causative organisms; AND Patient has had a trial and therapeutic failure of amphotericin B. ALL OTHER INDICATIONS: Patient has trial and failure, contraindication, or intolerance to fluconazole.

INDEX