



## 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

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## Products Affected

- VERZENIO

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

# ABIRATERONE

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## Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*

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

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## Products Affected

- DYSPOORT

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Cervical dystonia, Spasmodic torticollis: 18 years of age or older. Lower or upper limb spasticity: 2 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months. IL: 12 months
<b>Other Criteria</b>	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

# ACETAMINOPHEN-BENZHYDROCODONE

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## Products Affected

- APADAZ
- *benzhydrocodone-acetaminophen*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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 hydrocodone or acetaminophen.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a pain management specialist
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Patient has a diagnosis of acute pain; AND Patient has had a documented trial and failure, contraindication per FDA label, intolerance to at least TWO of the following: hydromorphone, oxycodone, oxycodone/acetaminophen, or hydrocodone/acetaminophen.

# ACITRETIN

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## Products Affected

- *acitretin*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a dermatologist
<b>Coverage Duration</b>	INITIAL: 3 months. RENEWAL: 1 year. IL: 12 months
<b>Other Criteria</b>	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

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## Products Affected

- *acyclovir topical ointment*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	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
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	UVEITIS: Isolated anterior uveitis
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>RA:</b> 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.</p> <p><b>PJIA:</b> (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.</p> <p><b>PsA:</b> Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.</p> <p><b>AS:</b> Patient had a previous trial of or contraindication to an NSAID.</p> <p><b>PsO:</b> (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.</p> <p><b>CD/UC:</b> Trial of or contraindication to one conventional agent such as corticosteroids (i.e., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine.</p> <p><b>UVEITIS:</b> Documentation of patients current weight if between 2 to 17 years of age.</p> <p><b>RENEWAL:</b></p>

PA Criteria	Criteria Details
	<p>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.</p> <p>PJIA/PsA: Patient experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy</p> <p>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.</p> <p>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.</p> <p>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.</p>

# ADEFOVIR

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## Products Affected

- *adefovir*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an infectious disease physician, gastroenterologist, hepatologist, or transplant physician
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

# AFATINIB

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## Products Affected

- GILOTRIF

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

# ALBENDAZOLE

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## Products Affected

- *albendazole*

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 Infectious Disease specialist.
Coverage Duration	Hydatid Disease: 6 months Neurocysticercosis: 1 month
Other Criteria	Patient has a confirmed diagnosis of one of the following (1) Parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm ( <i>Taenia solium</i> ) (2) Cystic hadatid disease of the liver, lung, and peritoneum caused by larval form of the dog tapeworm ( <i>Echinococcus granulosus</i> ).

# ALCAFTADINE

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## Products Affected

- LASTACRAFT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Patient has a diagnosis of allergic conjunctivitis; AND Patient has had a trial and failure, intolerance, or contraindication to at least TWO (2) of the following: azelastine 0.05% ophthalmic solution, cromolyn sodium solution 4%, epinastine 0.05% ophthalmic solution, olopatadine 0.1% ophthalmic solution.

# ALENDRONATE SODIUM/VITAMIN D3

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## Products Affected

- FOSAMAX PLUS D

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Monotherapy for vitamin D deficiency. Abnormalities of the esophagus which delay esophageal emptying such as stricture or achalasia. Inability to stand or sit upright for at least 30 minutes. Hypocalcemia
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a trial and failure or intolerance to therapy with alendronate or risedronate once weekly and vitamin D supplement taken concurrently as separate ingredients

# ALOSETRON HCL

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## Products Affected

- *alosetron*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Male patients. Constipation. History of chronic or severe constipation or with a history of sequelae from constipation. History of intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. History of ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state. Crohns disease, ulcerative colitis, and/or diverticulitis. Severe hepatic impairment. Concomitant administration with fluvoxamine
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Duration of therapy: ONE MONTH. Renewal: 6 months. IL: 12 months



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b>  Patient has a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) defined by documentation of at least ONE of the following: (1) frequent and severe abdominal pain/discomfort, (2) frequent bowel urgency or fecal incontinence, (3) disability or restriction of daily activities due to IBS; AND Patient has chronic IBS symptoms generally lasting 6 months or longer; AND Patient has had anatomic or biochemical abnormalities of the gastrointestinal tract ruled out; AND Patient has not responded adequately to conventional therapy including a trial and therapeutic failure of: (1) dietary changes (including fiber), stress reduction, and other behavioral changes, (2) antidiarrheals (e.g., loperamide, diphenoxylate and atropine), (3) antidepressants (e.g., desipramine, imipramine), (4) antispasmodics (e.g., dicyclomine, hyoscyamine).</p> <p><b>RENEWAL:</b> Prescriber attests to clinical notes demonstrating adequate control of IBS symptoms</p>

# AMINOCAPROIC ACID

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## Products Affected

- *aminocaproic acid oral tablet*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	Patients with active intravascular clotting process or disseminated intravascular coagulation (DIC) without concomitant heparin.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	Documented diagnosis of hemorrhage caused by hyperfibrinolysis secondary to various disorders including APLASTIC ANEMIA, ABRUPTIO PLACENTAE, HEPATIC CIRRHOSIS, and NEOPLASTIC DISEASES; OR aminocaproic acid is being used to enhance hemostasis when fibrinolysis contributes to bleeding in conditions such as: a) Bleeding in the urinary tract due to various etiologies b) SICKLE CELL ANEMIA with hematuria (sickling in the vas recta or renal papillary necrosis) c) Hemorrhagic cystitis d) surgery.

# ANABOLIC STEROIDS

## Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications. Anadrol-50: Fanconis anemia, cachexia associated with AIDS. Oxandrin: Cachexia associated with AIDS, Turners syndrome
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	<p>INITIAL:</p> <p>CACHEXIA ASSOCIATED WITH AIDS:</p> <p>1) Patient has a documented viral load (with date) of less than 200 copies per mL within the past 3 months.</p> <p>2) Patient meets one of the following:</p> <p>a) 10% unintentional weight loss over 12 months</p> <p>b) 7.5% unintentional weight loss over 6 months</p> <p>c) 5% body cell mass (BCM) loss within 6 months</p> <p>d) Body cell mass (BCM) of less than 35% (men) and a body mass index (BMI) of less than 27 kg per meter squared</p> <p>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</p> <p>f) BMI of less than 18.5 kg per meter squared.</p> <p>RENEWAL: 1) Patient has a documented viral load (with date) of less than 200 copies per mL within the past 3 months</p> <p>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)</p>
<b>Age Restrictions</b>	None

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	CACHEXIA ASSOCIATED WITH AIDS: Prescribed by or in consultation with a gastroenterologist, nutritional Support Specialist (SBS) or Infectious Disease specialist
<b>Coverage Duration</b>	ANM: 6 mo and IL: 12 mo For PROT CTB, BONE PAIN OP, TRNRS: 6 mo CCHX AIDS, WT GN: 12 wk.
<b>Other Criteria</b>	<p>INITIAL:</p> <p>ANEMIA: 1) Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes, 2) The request is for Anadrol-50.</p> <p>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</p> <p>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</p> <p>RENEWAL:</p> <p>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</p>

# APOMORPHINE

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## Products Affected

- APOKYN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Concomitant use with 5HT2 antagonists, including antiemetics (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron). Hypersensitivity to sodium metabisulfite.
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in conjunction with, a neurologist
Coverage Duration	12 months
Other Criteria	<b>INITIAL</b> (1) Patient has diagnosis of Advanced Parkinsons Disease with acute, intermittent hypomobility (off) episodes; AND (2) Apokyn will be used in combination with a levodopa containing product AND another anti-Parkinsons agent (i.e. dopamine agonist or COMT inhibitor). <b>RENEWAL</b> (1) Apokyn will be used in combination with a levodopa containing product AND another anti-Parkinsons agent (i.e. dopamine agonist or COMT inhibitor); AND (2) Patient has experienced a reduction in hypomobility (off) episodes.

# APREMILAST

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## Products Affected

- OTEZLA
- OTEZLA STARTER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>PsA:</b> Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.</p> <p><b>Mild PsO:</b> (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.</p> <p><b>Moderate to Severe PsO:</b> (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.</p> <p><b>ORAL ULCERS ASSOCIATED WITH BEHCETS DISEASE:</b> Trial of or contraindication to ONE or more conservative treatments (e.g., colchicine, topical corticosteroid, oral corticosteroid, etc.).</p> <p><b>RENEWAL:</b></p> <p><b>PsA:</b> Patient experienced or maintained a 20% or greater improvement in tender or swollen joint count while on therapy.</p> <p><b>Mild PsO:</b> 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.</p> <p><b>Moderate PsO:</b> Patient achieved or maintained clear or minimal disease or a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more.</p> <p><b>ORAL ULCERS ASSOCIATED WITH BEHCETS DISEASE:</b> Patient achieved or maintained clinical benefit compared to baseline (e.g., pain scores, number of ulcers, etc.).</p>

# ARIPIPRAZOLE

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## Products Affected

- ABILIFY MAINTENA
- *aripiprazole oral solution*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	History of a hypersensitivity reaction to aripiprazole.
<b>Required Medical Information</b>	Medication usage (trial and failure, intolerance, contraindication) must be supported by documentation from the patient's chart notes/medical records/electronic claim history.
<b>Age Restrictions</b>	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.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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,</p>
	<p>amphetamine/dextroamphetamine (medication usage must be supported by documentation from the patients chart notes/medical records/electronic claim history).</p>

# ARMODAFINIL

## Products Affected

- *armodafinil*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	Treatment for the underlying obstruction in OSA. Patients with known hypersensitivity to modafinil.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p><b>NARCOLEPSY:</b> 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.</p> <p><b>SHIFT WORK SLEEP DISORDER:</b> 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).</p> <p><b>OBSTRUCTIVE SLEEP APNEA:</b> 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.</p>

# ASENAPINE

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## Products Affected

- *asenapine maleate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	Known hypersensitivity to asenapine
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Bipolar I disorder, Monotherapy - 10 years of age and older All other indications : 18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Treatment of more severe episodes of PCP. Patients who are failing therapy with TMP-SMX for PCP.
<b>Required Medical Information</b>	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/mm <sup>3</sup> within the last 3 months; OR documentation the member had an episode of PCP that occurred at a CD4 count greater than 200cells/mm <sup>3</sup> while the member was on antiretroviral therapy
<b>Age Restrictions</b>	13 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an Infectious Disease specialist, oncologist, or HIV specialist.
<b>Coverage Duration</b>	INITIAL: PCP treatment: 21 days. PCP prophyl: 12 mos. RENEWAL: PCP prophyl: 12 mos.
<b>Other Criteria</b>	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

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## Products Affected

- INLYTA

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

# AZATHIOPRINE

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## Products Affected

- AZASAN

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

# AZELASTINE/FLUTICASONE

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## Products Affected

- *azelastine-fluticasone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of seasonal allergic rhinitis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO (2) generic intranasal steroid products, one of which must be intranasal generic fluticasone; AND Patient must have a minimum 2-week trial of an intranasal steroid in combination with azelastine

# AZITHROMYCIN

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## Products Affected

- AZASITE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Patient has a diagnosis of bacterial conjunctivitis caused by susceptible isolates of the following microorganisms: CDC coryneform group G, Haemophilus influenzae, Staphylococcus aureus, Streptococcus mitis group, Streptococcus pneumoniae
<b>Age Restrictions</b>	1 year of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	7 days
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure, intolerance, or contraindication to a trial of at least TWO of the following: ciprofloxacin ophthalmic solution, gatifloxacin ophthalmic solution, levofloxacin ophthalmic solution, moxifloxacin ophthalmic solution, ofloxacin ophthalmic solution, tobramycin ophthalmic solution sulfacetamide solution 10% ophthalmic solution, polymyxin B sul-trimethoprim ophthalmic solution



# BECAPLERMIN

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## Products Affected

- REGRANEX

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Treatment of pressure ulcers and venous stasis ulcers. Treatment of diabetic neuropathic ulcers that do not extend through the dermis into subcutaneous tissue [Stage I or II, International Association of Enterostomal Therapy (IAET) staging classification] or ischemic diabetic ulcers. Use in wounds that close by primary intention. Patients with known neoplasm(s) at the site(s) of application.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	Patient has a diagnosis of Diabetic Neuropathic Ulcer; AND Ulcer(s) must be on lower extremity with adequate blood supply; AND Ulcer(s) is confirmed full-thickness ulcer (i.e., Stage III or IV), extending through dermis into subcutaneous tissues; AND Patients wound is free from infection. Note: If complete healing has not occurred in 20 weeks of treatment, continued treatment with REGRANEX should be reassessed

# BEDAQUILINE FUMARATE

## Products Affected

- SIRTURO ORAL TABLET 100 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications and pulmonary extensively drug resistant tuberculosis (XDR-TB)
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS (MDR-TB), USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS: 5 years of age or older PULMONARY MDR-TB OR PULMONARY XDR-TB, USED IN COMBINATION WITH PRETOMANID AND LINEZOLID: 18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	PULM MDR-TB, CMBO W/ 3 ANTIBX: 24 wk PULM MDR-TB, XDR-TB, CMBO W/ PRETOMANID AND LINEZOLID: 26 wk
<b>Other Criteria</b>	PULMONARY MDR-TB: (1) Sirturo will be used in combination with (a) at least 3 other antibiotics OR (b) pretomanid and linezolid. (2) If patient is 5 to less than 18 years of age and Sirturo will be used with at least 3 other antibiotics, patient must weigh at least 15kg.  PULMONARY XDR-TB: Sirturo will be used in combination with pretomanid and linezolid

# BEPOTASTINE

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## Products Affected

- *bepotastine besilate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure to at least TWO of the following: azelastine ophthalmic solution cromolyn sodium ophthalmic solution epinastine ophthalmic solution olopatadine 0.1% ophthalmic solution

# BESIFLOXACIN

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## Products Affected

- BESIVANCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	1 year of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in conjunction with an optometrist or ophthalmologist
<b>Coverage Duration</b>	7 days
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure, intolerance, or contraindication to a trial of at least TWO of the following ophthalmic agents: ciprofloxacin, ofloxacin, erythromycin, gentamycin, polymyxin B sulfate-trimethoprim ophthalmics

# BETAINE

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## Products Affected

- *betaine*
- CYSTADANE

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

# BETAXOLOL

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## Products Affected

- BETOPTIC S

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with sinus bradycardia, greater than a first degree atrioventricular block, cardiogenic shock, or patients with overt cardiac failure.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of chronic open-angle glaucoma or ocular hypertension; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO of the following: betaxolol hcl ophthalmic solution, carteolol hcl ophthalmic solution, levobunolol hcl ophthalmic solution, timolol maleate ophthalmic solution.

# BEXAROTENE

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## Products Affected

- *bexarotene*

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

# BOSUTINIB

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## Products Affected

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

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

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## 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	<p><b>SCHIZOPHRENIA:</b>            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.</p> <p><b>MAJOR DEPRESSIVE DISORDER:</b>            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.</p>

# BRIMONIDINE

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## Products Affected

- MIRVASO TOPICAL GEL WITH PUMP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	Hypersensitivity to brimonidine
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Diagnosis of persistent (nontransient) erythema of rosacea; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic topical metronidazole.

# BRIVARACETAM

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## Products Affected

- BRIVIACT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to brivaracetam or any inactive ingredients in Briviact
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	1 month of age or older
<b>Prescriber Restrictions</b>	Prescribed by, or in conjunction with, a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of partial-onset seizures; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to levetiracetam AND at least ONE other anticonvulsant indicated for partial-onset seizures.

# BUPRENORPHINE PAIN

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## Products Affected

- BUPRENEX
- *buprenorphine*
- *buprenorphine hcl injection*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older prior to approval of Butrans 2 years of age or older prior to approval of Buprenex
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a pain management specialist.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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.</p> <p>(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.</p> <p>RENEWAL: (1) Prescriber attests that patient continues to meet initial criteria.</p>

# BUSULFAN

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## Products Affected

- *busulfan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	History of hypersensitivity to busulfan or any of its components
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

# CALCITONIN SALMON

## Products Affected

- *calcitonin (salmon) injection*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	Hypersensitivity of calcitonin-salmon or any component of the product Asymptomatic Pagets disease.
<b>Required Medical Information</b>	<p>Pagets Disease of Bone: Patient has moderate to severe disease characterized by polyostotic involvement with elevated serum alkaline phosphatase and urinary hydroxyproline excretion</p> <p>Hypercalcemia: Patients corrected total serum calcium is greater than or equal to 12 mg/dl (must provide documentation) OR greater than or equal to corrected total serum calcium of 6 mEq/L (must provide documentation).</p>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Hypercalcemia: 1 month, All others: 12 months. IL: 12 months
<b>Other Criteria</b>	<p>Pagets Disease of Bone: Patient has a diagnosis of symptomatic Pagets disease of bone; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO (2) oral bisphosphonates.</p> <p>Hypercalcemia: Patient has a documented diagnosis of hypercalcemia</p> <p>Postmenopausal osteoporosis: Patient has a diagnosis of postmenopausal osteoporosis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to a bisphosphonate or selective estrogen- receptor modulator (SERM); AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to calcitonin(salmon) nasal spray; AND Patient has a history of vertebral compression fractures, or fractures of the hip or distal radius resulting from minimal trauma, or T score of -2.5 or less.</p>

# CALCITRIOL OINTMENT

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## Products Affected

- *calcitriol topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with known or suspected disorders of calcium metabolism.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<b>MILD TO MODERATE PLAQUE PSORIASIS:</b> Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to a generic topical steroid (e.g., betamethasone dipropionate, clobetasol propionate, desoximetasone, or fluocinonide); AND Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to topical calcipotriene.



# CALCIUM ACETATE

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## Products Affected

- PHOSLYRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with hypercalcemia.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a nephrologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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 than 4.5mg/dl or calcium levels above 9.6 as documented by lab test for 2 to 3 consecutive months.

# CANNABIDIOL

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## Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	1 year of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	<p>INITIAL: DRAVET SYNDROME: Trial of or contraindication to clobazam AND valproic acid derivative LENNOX-GASTAUT SYNDROME: Trial of or contraindication to TWO of the following: clobazam, valproic acid derivative, topiramate, lamotrigine TUBEROUS SCLEROSIS COMPLEX: Trial of or contraindication to TWO antiepileptic medications (e.g. valproic acid derivatives, clobazam, topiramate, lamotrigine)</p> <p>RENEWAL: Diagnosis of seizures associated with Dravet syndrome, Lennox-Gastaut syndrome, OR tuberous sclerosis complex</p>

# CAPECITABINE

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## Products Affected

- *capecitabine oral tablet 150 mg, 500 mg*

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

# CARIPRAZINE

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## Products Affected

- VRAYLAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	Patients with hypersensitivity to cariprazine, including a history of angioedema to cariprazine.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Diagnosis of Schizophrenia, mania or mixed episodes associated with Bipolar Disorder (Bipolar 1 Disorder), or bipolar depression supported by chart notes/documentation, AND documented trial and failure, or contraindication to, THREE (3) formulary atypical antipsychotics (i.e., risperidone, quetiapine, olanzapine, ziprasidone, and aripiprazole)

# CERITINIB

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## Products Affected

- ZYKADIA ORAL TABLET

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

# CERTOLIZUMAB PEGOL

## Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST
- CIMZIA STARTER KIT

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	18 year of age or older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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,</p>

PA Criteria	Criteria Details
	<p>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.</p> <p>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 normal (b) Sacroiliitis on magnetic resonance imaging (MRI).</p> <p>RNWL: RA/PSA: Patient experienced or maintained 20% or more improvement in tender joint count or swollen joint count while on therapy.</p> <p>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.</p> <p>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.</p> <p>CD: Diagnosis of moderate to severe Crohns disease.</p>



# CETIRIZINE

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## Products Affected

- ZERVIAE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to cetirizine hydrochloride
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a trial and failure, intolerance, or contraindication to at least TWO (2) of the following: azelastine ophthalmic solution, cromolyn sodium ophthalmic solution, epinastine ophthalmic solution.

# CEVIMELINE

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## Products Affected

- *cevimeline*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with uncontrolled asthma. When miosis is undesirable, e.g., in acute iritis and in narrow-angle (angle-closure) glaucoma.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a documented trial and failure, intolerance, or contraindication to pilocarpine tablets.

# chlorambucil

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## Products Affected

- LEUKERAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients whose disease has demonstrated a prior resistance to the Leukeran. Patients who have demonstrated hypersensitivity to chlorambucil and other alkylating agents.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an oncologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

# CHLORZOXAZONE

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## Products Affected

- *chlorzoxazone oral tablet 500 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to chlorzoxazone
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a trial and failure, contraindication, or intolerance to at least TWO other muscle relaxants (e.g., baclofen 10mg, 20mg tablet, carisoprodol 350mg tablet, methocarbamol 500mg, 750mg tablets, or diazepam 2mg, 5mg, 10mg tablets).

# CHORIONIC GONADOTROPIN

## Products Affected

- CHORIONIC GONADOTROPIN, HUMAN INTRAMUSCULAR
- NOVAREL INTRAMUSCULAR RECON SOLN 10,000 UNIT
- PREGNYL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	HYPOGONADOTROPIC HYPOGONADISM (HH) 1. Patient has low testosterone (based on normal reference level) AND 2. Patient has low LH OR low FSH (based on normal reference level)
<b>Age Restrictions</b>	Infertility: 18 years of age and older; Prepubertal Cryptorchidism (PC): less than 13 years of age
<b>Prescriber Restrictions</b>	INFERTILITY: Reproductive endocrinologist or infertility specialist. HYPOGONADOTROPIC HYPOGONADISM (HH): Urologist. PREPUBERTAL CRYPTORCHIDISM (PC): Pediatric specialist
<b>Coverage Duration</b>	INFERTILITY: 1 mo. NC/CO: Total 3 tx cycles. IL: Total 4 tx cycles. HH: 1 yr. PC: 6 wks.
<b>Other Criteria</b>	A. FEMALE INFERTILITY 1. Patient has diagnosis of infertility AND 2. Patient has or will be pre-treated with a follicular stimulating agent (e.g., clomiphene) B. HYPOGONADOTROPIC HYPOGONADISM 1. Patient has diagnosis of hypogonadotropic hypogonadism C. PREPUBERTAL CRYPTORCHIDISM 1. Patient has diagnosis of prepubertal cryptorchidism not due to anatomical obstruction AND 2. Patient is not a candidate for surgery or drug will be used in combination with surgery

# CINACALCET

## Products Affected

- *cinacalcet*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Serum calcium level less than the lower limit of the normal range. Use in patients with CKD who are not on dialysis because of an increased risk of hypocalcemia.
<b>Required Medical Information</b>	INITIAL: SECONDARY HYPERPARATHYROIDISM, PARATHYROID CARCINOMA, PRIMARY HYPERPARATHYROIDISM Patients iPTH levels are greater than 300pg/mL (biPTH greater than 160), serum calcium levels greater than or equal to 8.4 mg/dL, phosphate levels between 3.5-5.5 and serum levels of calcium x phosphate product greater than or equal to 55 mg <sup>2</sup> /DL <sup>2</sup> .  RENEWAL: ALL INDICATIONS: iPTH levels must be greater than 150 pg/ml and calcium must be greater than or equal to 8.4 mg/dL.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL: 3 mo, FIRST RENEWAL: 6 mo, ADD RENEWALS: 12 mo. IL: 12 mo

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL: SECONDARY HYPERPARATHYROIDISM</b>  Patient has a documented diagnosis of secondary hyperparathyroidism due to chronic kidney disease; AND Patient is currently on dialysis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to calcium acetate or a sevelamer carbonate; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to Vitamin D/Vitamin D analog (i.e., calcitriol, Hectorol, etc.). (Medication usage must be supported by documentation from the patients chart notes/medical records).</p> <p><b>INITIAL: PARATHYROID CARCINOMA</b>  Patient has a documented diagnosis of hypercalcemia due to parathyroid carcinoma.</p> <p><b>INITIAL: PRIMARY HYPERPARATHYROIDISM</b>  Patient has s documented diagnosis of severe hypercalcemia due to primary hyperparathyroidism; AND Patient is unable to undergo parathyroidectomy.</p>

# CIPROFLOXACIN/HYDROCORTISONE

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## Products Affected

- CIPRO HC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	1 year of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO of the following: neomycin-polymyxin-HC otic suspension or otic solution, ofloxacin otic solution, ciprofloxacin 0.2% otic solution



# CLOBAZAM

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## Products Affected

- *clobazam*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of seizures associated with Lennox-Gastaut syndrome (supported by documentation from the patients chart notes/medical records); AND Patient is currently receiving treatment with at least one other antiepileptic medication (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 one of the following: lamotrigine, topiramate, or valproate (medication usage must be supported by documentation from the patients chart notes/medical records/electronic claim history).

# CLONIDINE HYDROCHLORIDE ER

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## Products Affected

- *clonidine hcl oral tablet extended release 12 hr*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with a history of hypersensitivity to clonidine.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months.
<b>Other Criteria</b>	Patient has a diagnosis of attention deficit hyperactivity disorder (ADHD); AND Patient has a documented intolerance, contraindication, or treatment failure with an adequate trial of immediate-release clonidine.

## Colistin/Hydrocortisone/Neomycin/Thonzonium

### Products Affected

- CORTISPORIN-TC

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	The external auditory canal disorder is suspected or known to be due to cutaneous viral infection (e.g., herpes simplex virus or varicella zoster virus). Hypersensitivity to any of the individual components (colistin sulfate, neomycin sulfate, thonzonium bromide and hydrocortisone acetate)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	1 year of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	10 days
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO (2) of the following: ciprofloxacin-dexamethasone otic suspension 0.3-0.1%, neomycin-polymyxin-hc otic solution, neomycin-polymyxin-hc, ofloxacin otic solution acetic acid otic solution.

# CRIZOTINIB

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## Products Affected

- XALKORI

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

# CYCLOSPORINE SOLUTION

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## Products Affected

- SANDIMMUNE ORAL SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with a hypersensitivity to Sandimmune (cyclosporine) and/or Cremophor EL (polyoxyethylated castor oil).
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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

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## Products Affected

- CYSTAGON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	Contraindicated in patients who have developed hypersensitivity to cysteamine or penicillamine.
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# DABRAFENIB

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## Products Affected

- TAFINLAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	ADJUVANT TREATMENT OF MELANOMA: Taflinar has been used for more than one year.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# DACARBAZINE

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## Products Affected

- *dacarbazine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to dacarbazine or any of its components.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in collaboration with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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

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## Products Affected

- *dalfampridine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older.
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with a neurologist.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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.</p> <p>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.</p>

# DALTEPARIN

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## Products Affected

- FRAGMIN SUBCUTANEOUS SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Acute treatment of VTE
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 6 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL</b></p> <p>A. Patient will be using Fragmin as prophylaxis therapy for ischemic complications in unstable angina and/or non-Q-wave myocardial infarction; AND Patient will be receiving concurrent aspirin therapy; OR</p> <p>B. Patient will be using Fragmin as prophylaxis for deep vein thrombosis (DVT) that may lead to pulmonary embolism (PE); AND</p> <p>a. Patient is undergoing hip replacement surgery; OR</p> <p>b. Patient is undergoing abdominal surgery; AND Patient is at risk for thromboembolic complications (NOTE: Abdominal surgery patients at risk include those who are over 40 years of age, obese, undergoing surgery under general anesthesia lasting longer than 30 minutes, or who have additional risk factors such as malignancy or a history of deep vein thrombosis or pulmonary embolism.); OR</p> <p>c. Patient is at risk for thromboembolic complications due to severely restricted mobility during acute illness, congestive heart failure (NYHA Class III or IV), acute respiratory failure not requiring ventilatory support, and the following acute conditions with at least one risk factor occurring in greater than 1% of treated patients: acute infection (excluding septic shock), acute rheumatic disorder, acute lumbar or sciatic pain, vertebral compression, or acute arthritis of the lower extremities); OR</p> <p>C. Patient has a cancer diagnosis; AND Patient will be using Fragmin for extended treatment of symptomatic venous thromboembolism (VTE) (proximal DVT and/or PE), to reduce the recurrence of VTE; OR</p> <p>D. Patient has a diagnosis of symptomatic venous thromboembolism (VTE); AND Patient will be using Fragmin to reduce the recurrence of VTE; AND</p> <p>E. Patient has had a trial and failure, intolerance, or contraindication to enoxaparin unless</p> <p>a. Enoxaparin is contraindicated OR</p> <p>b. (3b) History of clinically significant adverse effects to enoxaparin OR</p>
	<p>c. The requested use is FDA labeled for dalteparin but not for enoxaparin (i.e., VTE treatment in patients with cancer)</p> <p><b>RENEWAL</b></p> <p>Patient has previously met initial approval criteria; AND Patient is responding positively to therapy according to the provider.</p>

# DANAZOL

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## Products Affected

- *danazol*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	ENDOMETRIOSIS: Prescribed by, or in consultation with, a gynecologist. HEREDITARY ANGIOEDEMA: Prescribed by or in consultation with an allergist/immunologist.
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p><b>ENDOMETRIOSIS AMENABLE TO HORMONE MANAGEMENT:</b> Patient has a diagnosis of endometriosis confirmed by laparoscopy; <b>AND</b> 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; <b>AND</b> 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.</p> <p><b>HEREDITARY ANGIOEDEMA:</b> Patient has a diagnosis of hereditary angioedema; <b>AND</b> Danazol will be used as prophylactic therapy for the prevention of hereditary angioedema attacks.</p>

# DARBEPOETIN ALFA

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	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.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p><b>INITIAL:</b>            ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD): Hemoglobin level of less than 10g/dL.</p> <p>ANEMIA DUE TO CANCER CHEMOTHERAPY: Hemoglobin level of less than 11g/dL OR Hemoglobin level has decreased at least 2g/dL below baseline level.</p> <p>ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT: Hemoglobin level of less than 10g/dL.</p> <p><b>RENEWAL:</b>            ANEMIA DUE TO CKD: One of the following:            (1) Hemoglobin level of less than 10g/dL if not on dialysis            (2) Hemoglobin level of less than 11g/dL if on dialysis            (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.</p> <p>ANEMIA DUE TO CANCER CHEMOTHERAPY OR DUE TO CONCURRENT HEPATITIS C TREATMENT: Hemoglobin level between 10g/dL and 12g/dL.</p>
<b>Age Restrictions</b>	None

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	ANEMIA DUE TO CKD OR CANCER CHEM: 12 mo. ANEMIA D/T CONCURRENT HEP C TX: 6 mo. IL: 12 mo.
<b>Other Criteria</b>	<p>INITIAL: ALL INDICATIONS: Trial of Retacrit.</p> <p>ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT: Trial of or contraindication to ribavirin dose reduction.</p>



# DASATINIB

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## Products Affected

- SPRYCEL

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

# DEFERASIROX

## Products Affected

- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p><b>INITIAL:</b>  <b>CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS:</b> 2 lab values in the previous 3 months showing the patients serum ferritin levels are consistently greater than 1000mcg/L.</p> <p><b>CHRONIC IRON OVERLOAD RESULTING FROM NTD:</b> 2 lab values in the previous 3 months showing the patients serum ferritin levels are consistently greater than 300mcg/L</p> <p><b>RENEWAL:</b>  <b>CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS:</b> 2 lab values in the previous 3 months showing the patients serum ferritin levels are consistently greater than 500mcg/L.</p> <p><b>CHRONIC IRON OVERLOAD RESULTING FROM NTD:</b> One of the following (1) 2 lab values in the previous 3 months showing serum ferritin levels are consistently greater than 300mcg/L OR (2) patients liver iron concentration (LIC) is at least 3mg Fe/g dry weight.</p>
<b>Age Restrictions</b>	<p><b>CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS:</b> 2 years of age or older.</p> <p><b>CHRONIC IRON OVERLOAD RESULTING FROM NTD:</b> 10 years of age or older</p>
<b>Prescriber Restrictions</b>	Prescribed by or given in consultation with a hematologist or hematologist-oncologist
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	INITIAL: Requests for Jadenu sprinkle packets require a trial of equivalent generic Exjade or Jadenu tablets.

# DEFERIPRONE

## Products Affected

- *deferiprone oral tablet 500 mg*
- FERRIPROX ORAL SOLUTION
- FERRIPROX ORAL TABLET 500 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	RENEWAL: 2 lab values in the previous 3 months showing serum ferritin levels consistently greater than 500mcg/L
<b>Age Restrictions</b>	INITIAL/RENEWAL: Tablets: 8 years of age or older. Solution: 3 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or given in consultation with a hematologist or hematologist/oncologist
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months
<b>Other Criteria</b>	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).

# DELAFLORACIN

## Products Affected

- BAXDELA INTRAVENOUS
- BAXDELA ORAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications. Any other indication prescribed by or in consultation with an Infectious Disease (ID) specialist.
<b>Exclusion Criteria</b>	ACUTE BACTERIAL SKIN OR SKIN STRUCTURE INFECTION (ABSSSI): Diagnosis of animal or human bite, necrotizing fasciitis, diabetic foot infection, decubitus ulcer formation, myonecrosis or ecthyma gangrenosum
<b>Required Medical Information</b>	<p>ABSSSI:            One of the following:            1) Prescribed by or in consultation with an Infectious Disease (ID specialist) OR            2) Antimicrobial susceptibility testing shows susceptibility to delafloxacin and resistance to one standard of care agent for ABSSSI OR            3) If susceptibility results are unavailable, trial of or contraindication to one of the following agents for ABSSSI: gram positive targeting antibiotic (e.g., linezolid, clindamycin, doxycycline, Bactrim, vancomycin), penicillin antibiotic (e.g., amoxicillin), fluoroquinolone antibiotic (e.g., levofloxacin, ciprofloxacin, moxifloxacin), or cephalosporin antibiotic (e.g., ceftriaxone, cephalexin, cefazolin)</p> <p>COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP):            One of the following:            1) Therapy is prescribed by or in consultation with an Infectious Disease (ID specialist) OR            2) Antimicrobial susceptibility testing shows susceptibility to delafloxacin and resistance to at least two standard of care agents for community-acquired bacterial pneumonia (CABP) OR            3) If susceptibility results are unavailable, trial of or contraindication to at least two standard of care agents for community-acquired bacterial pneumonia (CABP) (e.g., macrolide, doxycycline, alternative fluoroquinolone, beta-lactam, linezolid)</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Age Restrictions</b>	ABSSSI/CABP: 18 year of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	ABSSI / OTHER INDICATION: 14 days CABP: 10 days
<b>Other Criteria</b>	None

# DENOSUMAB

## Products Affected

- PROLIA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypocalcemia. Pregnancy.
<b>Required Medical Information</b>	<p><b>OSTEOPOROSIS IN MEN AND WOMEN:</b>            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%.</p> <p><b>TREATMENT OF BONE LOSS IN MEN WITH PROSTATE CANCER:</b>            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%.</p>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>ALL INDICATIONS:</b>  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).</p> <p><b>OSTEOPOROSIS IN MEN AND WOMEN:</b>  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.</p> <p><b>GLUCOCORTICOID-INDUCED OSTEOPOROSIS:</b>  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.</p> <p><b>TREATMENT OF BONE LOSS IN MEN WITH PROSTATE CANCER:</b>  Patient is receiving androgen deprivation therapy for non-metastatic prostate cancer.</p>



PA Criteria	Criteria Details
	<p>TREATMENT OF BONE LOSS IN WOMEN WITH BREAST CANCER.:</p> <p>Patient is receiving adjuvant aromatase inhibitor therapy for breast cancer.</p> <p>NOTE:</p> <p>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.</p> <p>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.</p>

# DESMOPRESSIN SOLUTION

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## Products Affected

- *desmopressin injection*

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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.</p> <p>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.</p> <p>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.</p>

# DIFENOXIN/ATROPINE

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## Products Affected

- MOTOFEN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	<p>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.</p> <p>Patients with a known hypersensitivity to difenoxin, atropine, or any of the inactive ingredients.</p> <p>Patients who are jaundiced.</p>
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>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).</p>

# DIHYDROERGOTAMINE MESYLATE NASAL

## Products Affected

- *dihydroergotamine nasal*

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	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)

# DIMETHYL FUMARATE

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## Products Affected

- *dimethyl fumarate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Brand Tecfidera requires trial of generic dimethyl fumarate

# DOCETAXEL

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## 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)*

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



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>BREAST CANCER</b></p> <p>a. Patient has a diagnosis of locally advanced or metastatic breast cancer; AND has failed of prior chemotherapy.</p> <p>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.</p> <p><b>NON-SMALL CELL LUNG CANCER (NSCLC)</b></p> <p>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.</p> <p>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.</p> <p><b>PROSTATE CANCER</b></p> <p>Patient has a diagnosis of androgen independent (hormone refractory) metastatic prostate cancer; AND docetaxel will be used in combination with prednisone.</p> <p><b>GASTRIC ADENOCARCINOMA</b></p> <p>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.</p> <p><b>HEAD AND NECK CANCER</b></p> <p>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).</p>

# DORNASE ALFA

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## Products Affected

- PULMOZYME

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

# DOXEPIN CREAM

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## Products Affected

- *doxepin topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved Indications.
<b>Exclusion Criteria</b>	Patients with untreated narrow angle glaucoma Patient with a tendency to urinary retention
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month. IL: 12 months
<b>Other Criteria</b>	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.

# DOXERCALCIFEROL

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## Products Affected

- *doxercalciferol oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of secondary hyperparathyroidism associated with one of the following diagnoses: Stage 3 or 4 chronic kidney disease not yet requiring dialysis (pre-dialysis) AND Patient has had a clinical trial and failure, intolerance, or contraindication to calcitriol; OR Stage 5 chronic kidney disease requiring dialysis AND Patient has a serum intact parathyroid hormone (iPTH) level greater than 10 pg/mL

# DUPILUMAB

## Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>ATOPIC DERMATITIS:</b>  <b>INITIAL:</b> (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  <b>RENEWAL:</b> (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)</p> <p><b>MODERATE TO SEVERE ASTHMA:</b>  <b>INITIAL:</b> (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  <b>RENEWAL:</b> 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</p>

PA Criteria	Criteria Details
	<p>hospitalizations e.) Decrease in ER visits OR f.) Decrease in unscheduled visits to healthcare provider. C.</p> <p><b>CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP): INITIAL:</b> (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</p> <p><b>RENEWAL:</b> Documentation that the patient has responded to Dupixent as determined by the prescribing physician.</p>

# ELBASVIR/GRAZOPRE VIR

## Products Affected

- ZEPATIER

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	(1) Limited life expectancy (less than 12 months) due to non-liver related comorbid conditions. (2) Zepatier will be taken concurrently with Sovaldi (sofosbuvir). (3) Moderate to severe hepatitis impairment (Child-Pugh B or C). (4) Currently taking any of the following medications: phenytoin, carbamazepine, rifampin, efavirenz (e.g., Atripla, Sustiva), atazanavir (e.g., Evotaz, Reyataz), darunavir (e.g., Prezco bix, Prezista), lopinavir, saquinavir, tipranavir, cyclosporine, nafcillin, ketoconazole, modafinil, bosentan, etravirine, elvitegravir/cobicistat/emtricitabine/tenofovir (e.g., Stribild, Genvoya), atorvastatin at doses higher than 20mg daily, or rosuvastatin at doses greater than 10mg daily
<b>Required Medical Information</b>	(1) Recent HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months. (2) For genotype 1a :testing for NS5A resistance-associated polymorphisms.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	Coverage duration will be applied consistent with current AASLD/IDSA guidance.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	(1) Criteria will be applied consistent with current AASLD/IDSA guidance. (2) Contraindication to Epclusa and Harvoni, OR failed a short trial with Epclusa or Harvoni (e.g., inability to tolerate, adverse effect early in therapy). [NOTE: An individual who has completed a full course of therapy with Harvoni or Epclusa that did not achieve SVR will not be approved.]

# ELTROMBOPAG

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## Products Affected

- PROMACTA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	RENEWAL: CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA (cITP): A clinical response, as defined by an increase in platelet count to at least 50,000 per microliter.
<b>Age Restrictions</b>	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA (cITP): 1 year of age or older. APLASTIC ANEMIA: 12 years of age or older.
<b>Prescriber Restrictions</b>	cITP: Prescribed by or in consultation with a hematologist or immunologist.
<b>Coverage Duration</b>	INITIAL: cITP: 2 mo. RENEWAL: cITP: 12 mo. INITIAL/RENEWAL: All others: 12 mo. IL: 12 mo
<b>Other Criteria</b>	INITIAL: cITP: Trial of or contraindication to corticosteroids or immunoglobulins, or an insufficient response to splenectomy.

# ENASIDENIB

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## Products Affected

- IDHIFA

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

# ENDOTHELIN RECEPTOR ANTAGONISTS

## Products Affected

- *ambrisentan*
- *bosentan*
- OPSUMIT

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications
<b>Exclusion Criteria</b>	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): (1) Idiopathic pulmonary fibrosis (Letairis and Tracleer only), (2) Concurrently taking cyclosporine A or glyburide (Tracleer only).
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	TRACLEER: PULMONARY ARTERIAL HYPERTENSION: 3 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	INITIAL/RENEWAL: PAH: 12 months.
<b>Other Criteria</b>	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.

# ENZALUTAMIDE

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## Products Affected

- XTANDI

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/RENEWAL: 12 months
Other Criteria	<p>INITIAL: NON-METASTATIC CASTRATION RESISTANT PROSTATE CANCER (CRPC): Patient has high risk prostate cancer (i.e. rapidly increasing prostate specific antigen [PSA] levels) CRPC (NON-METASTATIC AND METASTATIC) OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): Patient meets one of the following: (1) Previously received a bilateral orchiectomy, or (2) Patient has a 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)</p> <p>RENEWAL: Diagnosis of CRPC (non-metastatic and metastatic) or MCSPC.</p>

# EPOETIN ALFA-EPBX

## Products Affected

- RETACRIT

PA Criteria	Criteria Details
<b>Covered Uses</b>	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.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p>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.</p> <p>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.</p>
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None

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

# ERAVACYCLINE

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## Products Affected

- XERAVA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with known eravacycline hypersensitivity or tetracyclines hypersensitivity. For treatment of complicated urinary tract infections (cUTI).
<b>Required Medical Information</b>	Diagnosis of complicated intraabdominal infections (cIAI) caused by susceptible microorganisms: Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii, Enterobacter cloacae, Klebsiella oxytoca, Enterococcus faecalis, Enterococcus faecium, Staphylococcus aureus, Streptococcus anginosus group, Clostridium perfringens, Bacteroides species, or Parabacteroides distasonis supported by chart notes/documentation.
<b>Age Restrictions</b>	18 years of age and older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month.
<b>Other Criteria</b>	None



# 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	<p><b>INITIAL:</b>  <b>EPISODIC MIGRAINES:</b> Trial of ONE of the following preventative migraine treatments: valproic acid/divalproex sodium, topiramate, propranolol, timolol, metoprolol, amitriptyline, venlafaxine, atenolol, nadolol  <b>CHRONIC MIGRAINES:</b> 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]</p> <p><b>RENEWAL:</b> 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</p>

# ERGOLOID MESYLATES ORAL

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## Products Affected

- *ergoloid*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	INITIAL/RENEWAL: 18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	<p>INITIAL</p> <ol style="list-style-type: none"> <li>1. Diagnosis of Alzheimers disease, vascular dementia, or primary progressive dementia supported by documentation.</li> <li>2. Patient intolerance to, or adequate trial of TWO of the following: galantamine, donepezil or rivastigmine.</li> </ol> <p>RENEWAL</p> <ol style="list-style-type: none"> <li>1. Documented positive clinical response to ergoloid therapy.</li> </ol>

# ERLOTINIB

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## Products Affected

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

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

# ESLICARBAZEPINE

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## Products Affected

- APTIOM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to eslicarbazepine acetate or oxcarbazepine
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	4 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has diagnosis of Partial-Onset Seizures; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO other formulary treatments (carbamazepine, oxcarbazepine, phenytoin, topiramate, pregabalin, valproic acid, zonisamide, divalproex, gabapentin, lamotrigine, levetiracetam, etc.)

# ESTRAMUSTINE PHOSPHATE SODIUM

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## Products Affected

- EMCYT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of metastatic and/or progressive prostate cancer; AND Emcyt (extramustine phosphate sodium) is being used for palliative treatment.

# ETANERCEPT

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## Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	INITIAL: 6 months, RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>RA:</b> 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.</p> <p><b>PJIA:</b> Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.</p> <p><b>PsA:</b> Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.</p> <p><b>AS:</b> Trial of or contraindication to an NSAID (e.g., naproxen, ibuprofen, diclofenac).</p> <p><b>PsO:</b> (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.</p> <p><b>RENEWAL:</b></p> <p><b>RA/PJIA/PsA:</b> Patient experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.</p> <p><b>AS:</b> 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.</p> <p><b>PsO:</b> 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.</p>

# ETHACRYNIC ACID

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## Products Affected

- *ethacrynic acid*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Patients with anuria. Patients that have experienced severe, watery diarrhea with previous treatment with ethacrynic acid
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	1 year of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>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.</p> <p>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.</p>



# EVEROLIMUS

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## Products Affected

- *everolimus (antineoplastic) oral tablet 2.5 mg, 5 mg, 7.5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Afinitor Disperz: SEGA-TSC: 1 year of age or older. TSC-associated partial-onset seizures: 2 years of age or older.  Afinitor: HR-positive, HER2-negative breast cancer: postmenopausal. NET: 18 years of age or older. RCC: 18 years of age or older. Renal angiomyolipoma-TSC: 18 years of age or older. SEGA-TSC: 1 year of age or older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# EVEROLIMUS - ZORTRESS

## Products Affected

- *everolimus (immunosuppressive) oral tablet*  
0.25 mg, 0.5 mg, 0.75 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Zortress is contraindicated in patients with known hypersensitivity to everolimus and sirolimus. Kidney transplant patients at high immunologic risk Recipients of transplanted organs other than kidney and liver
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a transplant specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	At least ONE of the following: (i) Has had a trial and failure on an anti-rejection regiment containing at least two of the following: (a) cyclosporine (b) tacrolimus (c) azathioprine (d) mycophenolate mofetil/sodium AND has one of the following indications: (i) kidney transplant rejection prophylaxis in patients at low-moderate immunologic risk OR (ii) liver transplant rejection prophylaxis

# FENTANYL TRANSDERMAL PATCH

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## Products Affected

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

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

# FIDAXOMICIN

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## Products Affected

- DIFICID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Patient has diagnosis of C. difficile-associated diarrhea (CDAD) confirmed by a positive stool assay
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an infectious disease specialist.
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	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

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## Products Affected

- NIVESTYM

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

# FINGOLIMOD

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## Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	(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)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	10 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# FLUCYTOSINE

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## Products Affected

- *flucytosine*

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 infectious disease specialist.
Coverage Duration	12 months
Other Criteria	Patient has a documented and confirmed diagnosis of Cryptococcus Meningitis or pulmonary infection OR Candida septicemia, endocarditis or urinary system infection AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to least one first-line agent (e.g. fluconazole, itraconazole, voriconazole, amphotericin B, or an echinocandin); AND for systemic candidiasis or cryptococcosis ONLY Patient will be using flucytosine in combination with amphotericin B.

# FLURANDRENOLIDE

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## Products Affected

- *flurandrenolide topical cream*
- *flurandrenolide topical lotion*

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



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>Patient has a diagnosis of corticosteroid responsive dermatoses and meets ALL of the following criteria: (1) Patient has had a trial and therapeutic failure, intolerance, or contraindication to ALL of the formulary preferred medium potency topical steroid alternatives: betamethasone valerate 0.1% cream and lotion, fluocinolone 0.025% cream and ointment, fluticasone 0.05% cream, hydrocortisone butyrate 0.1% solution and ointment, mometasone 0.1% cream and ointment, and triamcinolone 0.1% cream, lotion and ointment (2) If the preferred medium potency alternative trials are completed AND do not yield adequate relief, a clinical reason is provided for requesting flurandrenolide (a non-preferred alternative with the same potency) instead of trying a formulary high potency topical steroid alternative: (a) Medium to high potency: betamethasone dipropionate 0.05% cream and fluticasone 0.05% ointment (b) High potency: betamethasone dipropionate 0.05% ointment, betamethasone valerate 0.1% ointment, desoximetasone 0.25% cream, diflorasone 0.05% cream, triamcinolone 0.5% cream and ointment, and fluocinonide 0.05% gel, ointment and cream (c) Ultra high potency: betamethasone dipropionate augmented 0.05% cream, gel, lotion and ointment, clobetasol 0.05% solution, diflorasone 0.05% ointment (3) If requesting Cordran 0.025% cream, the patient needs to have a history of trial and failure, contraindication, or intolerance to Cordran 0.05% cream</p>

# FOLLITROPIN ALFA

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## Products Affected

- GONAL-F RFF REDI-JECT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a reproductive endocrinologist or infertility specialist
<b>Coverage Duration</b>	1 mo. Max 2 renews (3 tx cycles) for CO or NC, or 3 renews (4 tx cycles) for IL
<b>Other Criteria</b>	A. FEMALE INFERTILITY 1. Patient has diagnosis of infertility AND 2. Cause of infertility is not due to primary ovarian failure AND 3. Must have tried and failed, have an intolerance to, or contraindication to clomiphene

# FONDAPARINUX

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## Products Affected

- *fondaparinux*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p data-bbox="464 268 1365 533"> <b>Prophylaxis of Deep Vein Thrombosis</b>  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. </p> <p data-bbox="464 575 1325 722"> <b>Treatment of Acute Deep Vein Thrombosis</b>  Patient has a diagnosis of acute deep vein thrombosis; AND fondaparinux will be administered in conjunction with warfarin sodium. </p> <p data-bbox="464 764 1349 911"> <b>Treatment of Acute Pulmonary Embolism</b>  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. </p>

# FORMOTEROL

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## Products Affected

- *formoterol fumarate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Treatment of asthma
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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

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## Products Affected

- *fulvestrant*

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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.</p> <p>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.</p>

# GALCANEZUMAB-GNLM

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## Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE

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



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b>  <b>EPISODIC MIGRAINES:</b> Trial of ONE of the following preventative migraine treatments: valproic acid/divalproex sodium, topiramate, propranolol, timolol, metoprolol, amitriptyline, venlafaxine, atenolol, nadolol  <b>CHRONIC MIGRAINES:</b> 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]</p> <p><b>RENEWAL:</b>  <b>EPISODIC/CHRONIC MIGRAINES:</b> 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  <b>EPISODIC CLUSTER HEADACHE:</b> Improvement in episodic cluster headache frequency as compared to baseline.</p>

# GANCICLOVIR

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## Products Affected

- ZIRGAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	Patient has a documented diagnosis of herpetic keratitis; AND Patient has a documented intolerance, contraindication, or treatment failure with an adequate trial of trifluridine eye drops AND acyclovir oral tablets

# GANIRELIX

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## Products Affected

- *fyremadel*
- *ganirelix*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a reproductive endocrinologist or infertility specialist.
<b>Coverage Duration</b>	1 mo. NC/CO: Total 3 tx cycles. IL: Total 4 tx cycles.
<b>Other Criteria</b>	A. FEMALE INFERTILITY 1. Patient has diagnosis of infertility AND 2. Will be used in conjunction with assisted reproductive technology

# GEMCITABINE IV

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## Products Affected

- *gemcitabine*

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>OVARIAN CANCER:</b>  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.</p> <p><b>BREAST CANCER:</b>  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.</p> <p><b>NON-SMALL CELL LUNG CANCER:</b>  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.</p> <p><b>PANCREATIC CANCER:</b>  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.</p>

# GEMIFLOXACIN

## Products Affected

- FACTIVE

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Known sensitivity to gemifloxacin or quinolones.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with infectious disease specialist
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	<ol style="list-style-type: none"> <li>1. Documented diagnosis of acute bacterial exacerbation of chronic bronchitis or community acquired pneumonia, AND</li> <li>2. Patient intolerance to, or adequate trial of at least ONE formulary alternatives (ciprofloxacin, levofloxacin or ofloxacin), OR</li> <li>3. Isolated microorganism must be resistant to all other fluoroquinolones, AND</li> <li>4. Isolated microorganism is one of the following: Acinetobacter Iwoffii, Chlamydophila pneumoniae, Haemophilus influenzae (beta-lactamase negative), Haemophilus influenzae (beta-lactamase positive) Haemophilus parainfluenzae, Klebsiella oxytoca, Klebsiella pneumonia, Legionella pneumophila, Moraxella catarrhalis, Mycoplasma pneumoniae, Proteus vulgaris, Staphylococcus aureus (MSSA), Streptococcus pneumoniae, Streptococcus pyogenes (group A beta-hemolytic streptococci).</li> </ol>

# GLATIRAMER ACETATE

## Products Affected

- *glatiramer*
- *glatopa*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Consistent with FDA approved label
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	<p>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.)</p> <p>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.</p>

# GLECAPREVIR/PIBRENTASVIR

## Products Affected

- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	(1) Moderate or severe liver impairment (Child-Pugh B or C), (2) Currently taking any of the following medications (alone or in combination): rifampin, atazanavir, carbamazepine, efavirenz, darunavir, lopinavir, ritonavir, atorvastatin, lovastatin, simvastatin, rosuvastatin (at doses greater than 10mg), cyclosporine (for patients requiring stable cyclosporine doses greater than 100mg/day) or medications containing ethinyl estradiol, (3) Prior failure of a direct-acting antiviral (DAA) regimen that contains a NS5A inhibitor AND a NS3/4A protease inhibitor (e.g., Viekira Pak, Viekira XR, Technivie, Vosevi, Zepatier), or previous concurrent treatments containing a NS5A inhibitor AND NS3/4A protease inhibitor, (4) Limited life expectancy (less than 12 months) due to non-liver related comorbid conditions.
<b>Required Medical Information</b>	Chronic HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months.
<b>Age Restrictions</b>	3 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with 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
<b>Coverage Duration</b>	Coverage duration will be applied consistent with current AASLD/IDSA guidance.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>(1) Criteria will be applied consistent with current AASLD/IDSA guidance.</p> <p>(2) For genotype 1, 4, 5, or 6: a short trial of Epclusa or Harvoni (e.g., adverse effect early in therapy to Harvoni or Epclusa) or contraindication to BOTH agents</p> <p>(3) For genotype 2 or 3: a short trial of Epclusa (e.g., adverse effect early in therapy to Epclusa) or contraindication to this agent</p> <p>[NOTE: An individual who has completed a full course of therapy with Harvoni or Epclusa that did not achieve SVR will not be approved.]</p>

# GOLIMUMAB - IV (NSA)

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## Products Affected

- SIMPONI ARIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	RA, AS: 18 years of age or older PsA, pJIA: 2 years of age or older
<b>Prescriber Restrictions</b>	RA/AS/pJIA: Prescribed by or in consultation with a rheumatologist PsA: Prescribed by or in consultation with a rheumatologist or dermatologist
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>RA:</b> (1) Concurrently using or has a contraindication to methotrexate, (2) Trial of or contraindication to at least 3 months of treatment with at least ONE of the following DMARDs (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 (3) One of the following: (a) Trial of or contraindication to any TWO of the following preferred agents: Enbrel, Humira, Rinvoq, Xeljanz (IR/XR) (b) 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.</p> <p><b>PsA:</b> (1) Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine, AND (2) One of the following (a) Patient 2 to 17 years of age: trial or contraindication to the preferred agent: Cosentyx (b) Patients 18 years or older: Trial or contraindication to any TWO of the following preferred agents: Cosentyx, Enbrel, Humira, Stelara, Xeljanz (IR/XR), Otezla, Tremfya, Rinvoq, Skyrizi.</p> <p><b>AS:</b> (1) Trial of or contraindication to an NSAID, AND (2) Trial of or contraindication to TWO of the following preferred agents: Cosentyx, Enbrel, Humira, Xeljanz (IR/XR).</p> <p><b>PJIA:</b> (1) Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine, AND (2) Trial of or contraindication to any TWO of the following preferred agents: Enbrel, Humira, Actemra, Xeljanz IR.</p> <p>[NOTE: pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify for trials]</p> <p><b>RENEWAL:</b></p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>RA: (1) Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy, AND (2) Concurrently using or has a contraindication to methotrexate.</p> <p>PsA/PJIA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.</p> <p>AS: 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.</p>

# GOLIMUMAB - SQ

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## Products Affected

- SIMPONI

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>RA:</b> (1) Trial of or contraindication to at least 3 months of treatment with at least 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, (2) Concurrent use or contraindication to methotrexate, AND 3) One of the following (a) Trial of or contraindication to any TWO of the following preferred immunomodulators: Enbrel, Humira, Rinvoq, Xeljanz (IR/XR) (b) 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.</p> <p><b>PsA:</b> (1) Trial of or contraindication to at least ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine, AND (2) Trial of or contraindication to any TWO of the following preferred immunomodulators: Cosentyx, Enbrel, Humira, Stelara, Xeljanz (IR/XR), Otezla, Tremfya, Rinvoq, Skyrizi.</p> <p><b>AS:</b> (1) Trial of or contraindication to an NSAID, AND (2) Trial of or contraindication to any TWO of the following preferred immunomodulators: Cosentyx, Enbrel, Humira, Xeljanz (IR/XR).</p> <p><b>UC:</b> (1) Trial of or contraindication to at least ONE conventional agent, such as corticosteroids (i.e., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine, AND (2) Trial of or contraindication to the preferred immunomodulator Humira.</p> <p>[NOTE: pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify for trials]</p>

PA Criteria	Criteria Details
	<p>RENEWAL:</p> <p>RA: (1) Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy AND (2) Concurrent use or contraindication to methotrexate.</p> <p>PsA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.</p> <p>AS: 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.</p> <p>UC: Diagnosis of moderate to severe ulcerative colitis.</p>

# 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
<b>Covered Uses</b>	All FDA approved indications and gender dysphoria will also be considered for approval.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	CENTRAL PRECOCIOUS PUBERTY: 2 years of age or older.
<b>Prescriber Restrictions</b>	CPP: Prescribed by or in consultation with a pediatric endocrinologist
<b>Coverage Duration</b>	INIT/RNWL: GENDER DYSPHORIA, PROSTATE CANCER, or CPP: 12 m
<b>Other Criteria</b>	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 (NAFARELIN)

## Products Affected

- SYNAREL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications and gender dysphoria will also be considered for approval.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	ENDOMETRIOSIS: 18 years of age or older. CENTRAL PRECOCIOUS PUBERTY: 2 years of age or older.
<b>Prescriber Restrictions</b>	ENDOMETRIOSIS: Prescribed by or in consultation with an obstetrician/gynecologist. CPP: Prescribed by or in consultation with a pediatric endocrinologist
<b>Coverage Duration</b>	INIT/RNWL: GENDER DYSPHORIA, PROSTATE CANCER, or CPP: 12 mo. ENDOMETRIOSIS: 6 mo.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p>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).</p> <p>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).</p> <p><b>RENEWAL:</b></p> <p>A. ENDOMETRIOSIS: (1) Improvement of pain related to endometriosis while on therapy AND (2) Patient is receiving concomitant add-back therapy (e.g., combination estrogen-progestin or progestin-only contraceptive preparation) AND (3) patient has NOT received a total course of Synarel therapy exceeding 12 months.</p> <p>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.</p>

# 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
<b>Covered Uses</b>	All FDA approved indications and gender dysphoria will also be considered for approval.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	CENTRAL PRECOCIOUS PUBERTY (CPP): 2 years of age or older.
<b>Prescriber Restrictions</b>	ENDOMETRIOSIS: Prescribed by or in consultation with an obstetrician/gynecologist. CPP: Prescribed by or in consultation with a pediatric endocrinologist
<b>Coverage Duration</b>	INIT: UTERINE LEIOMY: 3 mo. INIT/RNWL: GENDR DYSPH, PROST CNCR, or CPP: 12 mo. ENDOMTRISIS: 6 mo.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p>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).</p> <p>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).</p> <p><b>RENEWAL:</b></p> <p>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.</p> <p>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.</p>

# GUSELKUMAB

## Products Affected

- TREMFYA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	PSORIASIS (PsO): Prescribed by or in consultation with a dermatologist. PSORIATIC ARTHRITIS (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months
<b>Other Criteria</b>	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*
- TAKHZYRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: History of anaphylactic or life-threatening hypersensitivity reactions to human C1 inhibitor, icatibant, ecellantide or any component of the formulation.
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Takhzyro: 12 years and older; Icatibant: 18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with medical geneticist, allergist, immunologist, or hematologist
<b>Coverage Duration</b>	Initial: 6 months. Renewal: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL: HAE ACUTE (ICATIBANT):</b>  (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</p> <p><b>INITIAL: HAE PROPHYLAXIS (TAKHZYRO):</b>  (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</p> <p><b>RENEWAL: HAE ACUTE (ICATIBANT):</b>  (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 occurrence 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</p>
	<p>attacks) currently on-hand. icatibant 6 syringes/30 days</p> <p><b>RENEWAL: HAE PROPHYLAXIS (TAKHZYRO):</b>  (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)</p>

# HYDROCODONE ER

## Products Affected

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

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

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## Products Affected

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

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

# IBRUTINIB

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## Products Affected

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

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

# IDELALISIB

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## Products Affected

- ZYDELIG

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

# ILOPROST

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## Products Affected

- VENTAVIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b>  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), <b>OR</b>  (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).</p> <p><b>RENEWAL:</b>  One of the following:  (1) Patient had improvement from baseline in the 6-minute walk distance test, <b>OR</b>  (2) Patient remained stable from baseline in the 6-minute walk distance test and the patients WHO functional class remained stable or has improved.</p>

# IMATINIB

## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	RELAPSED OR REFRACTORY PHILADELPHIA CHROMOSOME POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA (PH+ ALL); MYELOYDYSPLASTIC/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.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	ADJUV GASTROINTESTINAL STROMAL TUMOR: 36 mo. ALL OTHER DIAGNOSES: 12 mo
<b>Other Criteria</b>	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): No previous treatment with another tyrosine kinase inhibitor.

# IMMUNE GLOBULIN

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## Products Affected

- HYQVIA

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

# INSULIN GLULISINE

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## Products Affected

- APIDRA SOLOSTAR U-100 INSULIN
- APIDRA U-100 INSULIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Use during episodes of hypoglycemia
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has diagnosis of Diabetes Mellitus; AND Patient has had a previous trial and failure, intolerance, or contraindication to all of the following: (i) Novolin (ii) Novolog (iii) Fiasp



# INTERFERON ALFA-2B

## Products Affected

- INTRON A INJECTION RECON SOLN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	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.
<b>Prescriber Restrictions</b>	Must be prescribed by, or in conjunction with, a Gastroenterologist, Hepatologist, Oncologist or Infectious Disease Specialist
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p><b>MALIGNANT MELANOMA:</b> (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).</p> <p><b>FOLLICULAR NON-HODKINS LYMPHOMA:</b> (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.</p> <p><b>CONDYLOMATA ACUMINATA:</b> Patient has diagnosis of condylomata acuminata involving external surfaces of the genital and perianal areas.</p> <p><b>AIDS-RELATED KAPOSI SARCOMA:</b> Patient has diagnosis of AIDS-related Kaposi sarcoma.</p> <p><b>CHRONIC HEPATITIS C:</b> (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.</p>

# INTERFERON GAMMA-1B

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## Products Affected

- ACTIMMUNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months
<b>Other Criteria</b>	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

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## Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON
- EXTAVIA
- PLEGRIDY SUBCUTANEOUS

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

# ISAVUCONAZONIUM

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## Products Affected

- CRESEMBA ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Coadministration with strong CYP3A4 inhibitors, such as ketoconazole or high-dose ritonavir. Coadministration with strong CYP3A4 inducers, such as rifampin, carbamazepine, St. Johns wort, or long-acting barbiturates. Use in patients with familial short QT syndrome
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an Infectious Disease specialist
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure, intolerance, or contraindication to therapy with amphotericin B, posaconazole, or voriconazole.

# 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	<p>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.</p> <p>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.</p> <p>QUANTITY RESTRICTION, Maximum 60 capsules / 30 days</p>

# ITRACONAZOLE ORAL

## Products Affected

- *itraconazole*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<p>Concomitant administration of itraconazole with drugs metabolized by CYP3A4: oral midazolam, pimozide, quinidine, dofetilide, triazolam, lovastatin, and simvastatin.</p> <p>Treatment of onychomycosis to pregnant patients or to women contemplating pregnancy.</p> <p>Patients who have shown hypersensitivity to itraconazole.</p> <p>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.</p>
<b>Required Medical Information</b>	<p><b>ONYCHOMYCOSIS OF THE FINGERNAILS/TOENAILS:</b></p> <p>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.</p>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist.
<b>Coverage Duration</b>	Fingernl Onycho: 5 wk. Toenl Onycho: 12 wk. Histoplas/Blasto: 12 mo. Asperg: 6 mo. Candids: 2 mo

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p data-bbox="467 268 846 300"><b>ORAL CAPSULES ONLY</b></p> <p data-bbox="467 310 1414 491">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.</p> <p data-bbox="467 537 846 569"><b>ORAL SOLUTION ONLY</b></p> <p data-bbox="467 579 1398 722">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.</p> <p data-bbox="467 768 1365 1031">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.</p>



# IVABRADINE

## Products Affected

- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>A. STABLE, SYMPTOMATIC HEART FAILURE (NYHA II-IV)</b>  (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</p> <p><b>B. SYMPTOMATIC NYHA CLASS II-IV HEART FAILURE DUE TO DILATED CARDIOMYOPATHY</b> (1) Patient has diagnosis of symptomatic NYHA class II-IV heart failure due to dilated cardiomyopathy AND (2) In sinus rhythm.</p> <p><b>RENEWAL CRITERIA:</b>  (1) patient continues to meet initial criteria AND (2) patient has experienced disease stabilization or improvement with medication as determined by the prescriber.</p>

# LACOSAMIDE

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## Products Affected

- VIMPAT ORAL SOLUTION
- VIMPAT ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	4 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure, intolerance, or contraindication to a trial of at least TWO (2) formulary anticonvulsants.

# LACTULOSE

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## Products Affected

- KRISTALOSE
- *lactulose oral packet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients who require a low galactose diet.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of constipation; AND Patient has had a trial and failure, intolerance, or contraindication to generic lactulose solution.

# LANREOTIDE

## Products Affected

- *lanreotide*
- SOMATULINE DEPOT

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p><b>INITIAL: ACROMEGALY</b>            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).</p> <p><b>RENEWAL: ACROMEGALY</b>            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.</p>
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p><b>INITIAL: ACROMEGALY</b>            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.</p>

# LAPATINIB

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## Products Affected

- *lapatinib*

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

# LASMIDITAN

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## Products Affected

- REYVOW

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL: 6 months, RENEWAL: 12 months
<b>Other Criteria</b>	<p>INITIAL: Trial of or contraindication to ONE triptan (e.g., sumatriptan, rizatriptan).</p> <p>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.</p>

# LEDIPASVIR/SOFOSBUVIR

## Products Affected

- HARVONI

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	(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).
<b>Required Medical Information</b>	Recent HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months
<b>Age Restrictions</b>	3 years of age or older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	Coverage duration will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	(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

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## 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

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## 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 X 2), 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

# LEUPROLIDE-NORETHINDRONE

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## Products Affected

- LUPANETA PACK (1 MONTH)

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<p>INITIAL/RENEWAL:</p> <p>Premenarcheal adolescents.</p> <p>Hypersensitivity to gonadotropin-releasing hormone (GnRH), GnRH agonist analogs or norethindrone acetate.</p> <p>Undiagnosed abnormal uterine bleeding.</p> <p>Known, suspected or planned pregnancy during the course of therapy.</p> <p>Lactating women.</p> <p>Known, suspected or history of breast cancer or other hormone-sensitive cancer.</p> <p>Current or history of thrombotic or thromboembolic disorder.</p> <p>Liver tumors or liver disease.</p>
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a gynecologist.
<b>Coverage Duration</b>	Initial: 6 mo. Renewal: 6 mo (total lifetime max 12 mos). IL: 12 mo
<b>Other Criteria</b>	Renewal: The patient continues to meet the initial criteria

# LEVOFLOXACIN OPHTHALMIC

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## Products Affected

- *levofloxacin ophthalmic (eye) drops 0.5%*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with a history of hypersensitivity to levofloxacin or other quinolones
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	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

# LEVOMILNACIPRAN

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## Products Affected

- FETZIMA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to levomilnacipran or milnacipran HCl. Simultaneous use with or within 14 days of stopping a mono-amine oxidase inhibitor (MAOI). Use of MAOI within 7 days of stopping Fetzima. Starting Fetzima in an individual on Linezolid
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of Major Depressive Disorder (MDD); AND Patient has had a trial and therapeutic failure, contraindication, or intolerance to at least TWO (2) of the following: citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline; AND Patient has had a trial and therapeutic failure, contraindication, or intolerance to at least TWO (2) of the following: desvenlafaxine (Generic Pristiq), duloxetine, venlafaxine HCl ER (Capsule), venlafaxine HCl

# LIDOCAINE PATCH 5%

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## Products Affected

- *lidocaine topical adhesive patch, medicated 5%*

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>POSTHERPETIC NEURALGIA</b>  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)</p> <p><b>DIABETIC PERIPHERAL NEUROPATHY</b>  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.</p>

# LODOXAMIDE

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## Products Affected

- ALOMIDE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Patient has a diagnosis of vernal keratoconjunctivitis, vernal conjunctivitis, and/or vernal keratitis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO of the following azelastine ophthalmic solution cromolyn sodium ophthalmic solution epinastine ophthalmic solution olopatadine 0.1% ophthalmic solution



# LOMUSTINE

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## Products Affected

- GLEOSTINE

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

# LULICONAZOLE

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## Products Affected

- *luliconazole*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Tinea pedis/Tinea cruris: member is 12 years of age or older Tinea corporis: member is 2 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	Patient has a documented diagnosis of one of the following: tinea pedis, tinea cruris, and/or tinea corporis caused by <i>Trichophyton rubrum</i> and/or <i>Epidermophyton floccosum</i> ; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO (2) of the following: clotrimazole topical, econazole topical, ketoconazole topical, miconazole topical.

# LUMACAFITOR-IVACAFITOR

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## Products Affected

- ORKAMBI ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	INITIAL: Documentation that the patient is homozygous for the F508del-CFTR gene mutation
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or given in consultation with a pulmonologist or CF expert
<b>Coverage Duration</b>	INITIAL: 24 weeks. RENEWAL: Lifetime. IL: Initial 12 mo, Renewal: Lifetime
<b>Other Criteria</b>	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
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Strong CYP3A4 inhibitors (e.g., ketoconazole, clarithromycin, ritonavir, voriconazole, mibefradil, etc.). Strong CYP3A4 inducers (e.g., rifampin, avasimibe, St. Johns wort, phenytoin, carbamazepine, etc.).
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Bipolar depression: 10 years of age and older Schizophrenia: 13 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a psychiatrist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years to less than 18 years of age
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pediatric endocrinologist or a pediatric nephrologist
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months
<b>Other Criteria</b>	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

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## Products Affected

- *melphalan*
- *melphalan hcl*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients whose disease has demonstrated a prior resistance to this agent. Patients who have demonstrated hypersensitivity to melphalan
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>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.</p> <p>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.).</p>

# MEMANTINE ORAL SOLUTION

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## Products Affected

- *memantine oral solution*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Known hypersensitivity to memantine hydrochloride
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

# MENOTROPINS

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## Products Affected

- MENOPUR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a reproductive endocrinologist or infertility specialist.
<b>Coverage Duration</b>	1 mo. Max 2 renews (3 tx cycles) for CO or NC, or 3 renews (4 tx cycles) for IL
<b>Other Criteria</b>	A. FEMALE INFERTILITY 1. Patient has diagnosis of infertility AND 2. Will be used in conjunction with assisted reproductive technology or intrauterine insemination



# MESALAMINE

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## Products Affected

- *mesalamine rectal suppository*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with known or suspected hypersensitivity to salicylates or aminosalicylates
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a trial and failure, intolerance, or contraindication to all of the following: Mesalamine 1.2gm DR, Mesalamine 800mg DR and Mesalamine 4gm Enema.

# MESNA

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## Products Affected

- MESNEX ORAL

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

# METAXALONE

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## Products Affected

- *metaxalone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Known tendency to drug induced, hemolytic, or other anemias. Significantly impaired renal or hepatic function.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Patient has diagnosis of acute musculoskeletal pain; AND Patient has had a trial and therapeutic failure, contraindication, or intolerance to THREE of the following: (i) cyclobenzaprine (ii) orphenadrine (iii) chlorzoxazone (iv) methocarbamol

# METHOXSALEN

## Products Affected

- *methoxsalen*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<p>Patients exhibiting idiosyncratic reactions to psoralen compounds.</p> <p>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)</p> <p>Patients with melanoma or with a history of melanoma.</p> <p>Patients with invasive squamous cell carcinomas.</p> <p>Patients with aphakia because of the significantly increased risk of retinal damage due to the absence of lenses.</p>
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>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.</p>

# MIDAZOLAM

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## Products Affected

- NAYZILAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with known hypersensitivity to midazolam. Acute narrow-angle glaucoma
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of epilepsy AND Patient will be using Nayzilam for the acute treatment of intermittent episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) are distinct from usual seizure pattern with epilepsy AND Patient is currently receiving maintenance antiepileptic medication(s) (e.g., lamotrigine, gabapentin, topiramate, oxcarbazepine).

# MILNACIPRAN

## Products Affected

- SAVELLA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Use of MAOIs intended to treat psychiatric disorders with Savella or within 5 days of stopping treatment with Savella. Use of Savella within 14 days of stopping an MAOI intended to treat psychiatric disorders
<b>Required Medical Information</b>	FIBROMYALGIA: Patient has a documented diagnosis of Fibromyalgia confirmed by all of the following: (1) Physical exam indicating presence of 11 of 18 tender points, and (2a) Widespread Pain Index (WPI) greater than or equal to 7 and Symptom Severity (SS) scale score greater than or equal to 5, OR (2b) WPI is between 3 and 6 and SS scale score greater than or equal to 9.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist, physiatrist, neurologist, or pain management specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	FIBROMYALGIA: Symptoms have been present for at least 3 months; AND Other conditions mistaken for fibromyalgia have been ruled out (e.g. rheumatoid arthritis, peripheral neuropathies, infection); AND Patient has had a trial and failure, intolerance, or contraindication to a tricyclic antidepressant (i.e. amitriptyline) AND duloxetine.

# MILTEFOSINE

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## Products Affected

- IMPAVIDO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Leishmaniasis species is identified via ONE of the following CDC recommended tests: (1) Stained slides (using tissue from biopsy specimens, impression smears or dermal scrapings) (2) Culture medium (3) Polymerase chain reaction (PCR) (4) Serologic testing (e.g. rK39 Rapid Test)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# MIRABEGRON

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## Products Affected

- MYRBETRIQ ORAL TABLET  
EXTENDED RELEASE 24 HR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Known hypersensitivity to mirabegron.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	3 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	Quantity limit: 1 tablet per day. INITIAL: 1. Diagnosis of overactive bladder, neurogenic detrusor overactivity or other FDA approved indication supported by chart notes/documentation. 2. Documented trial and failure of, or contraindication to, adequate treatment with at least THREE (3) antimuscarinic agents (i.e. darifenacin, solifenacin, oxybutynin, tolterodine, or trospium)  RENEWAL: Patient has documented positive clinical response to Myrbetriq therapy.



# MITOTANE

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## Products Affected

- LYSODREN

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

# MODAFINIL

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## Products Affected

- *modafinil*

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>NARCOLEPSY:</b>  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.</p> <p><b>SHIFT WORK SLEEP DISORDER:</b>  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.</p> <p><b>OBSTRUCTIVE SLEEP APNEA:</b>  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.</p>

# NALDEMEDINE TOSYLATE

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## Products Affected

- SYMPROIC

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with a history of a hypersensitivity reaction to naldemedine. Patients with known or suspected gastrointestinal obstruction and patients at increased risk of recurrent obstruction
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of OIC with chronic non-cancer pain, including patients with chronic pain related to prior cancer treatment who do not require frequent (weekly) opioid dose escalation; AND Patient has been on opioid for at least 30 days; AND Patient has a documented intolerance, contraindication, or treatment failure with, an adequate trial of ONE agent from each of the following TWO classes while on opioid therapy: stimulant laxative (e.g., bisacodyl, senna) AND osmotic laxative (e.g., lactulose, polyethylene glycol).

# NALOXEGOL

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## Products Affected

- MOVANTIK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with known or suspected gastrointestinal obstruction and patients at increased risk of recurrent obstruction. Patients concomitantly using strong CYP3A4 inhibitors (e.g., clarithromycin, ketoconazole)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has been taking an opioid analgesic for at least 4 weeks immediately prior to the request (as evidenced by pharmacy claims) AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least one agent from within each of the following laxative types: (1) Fiber laxatives (psyllium, methylcellulose, calcium polycarbophil) AND (2) Stimulant laxatives (bisacodyl, senna) AND (3) Osmotic laxatives (Polyethylene glycol, milk of magnesia, sorbitol, lactulose)

# NALTREXONE MICROSPHERES

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## Products Affected

- VIVITROL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients receiving opioid analgesics. Patients with current physiologic opioid dependence. Patients in acute opioid withdrawal. Any individual who has failed the naloxone challenge test or has a positive urine screen for opioids. Patients who have previously exhibited hypersensitivity to naltrexone, PLG, carboxymethylcellulose, or any other components of the diluent
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p data-bbox="464 268 870 300"><b>ALCOHOL DEPENDENCE</b></p> <p data-bbox="464 308 1373 495">Patient must have already abstained from drinking alcohol; AND Vivitrol will be used as part of a comprehensive treatment program for alcohol dependence that should include a psychosocial support system; AND Patient has had a trial and failure, intolerance, or contraindication to oral naltrexone AND acamprosate.</p> <p data-bbox="464 537 824 569"><b>OPIOID DEPENDENCE</b></p> <p data-bbox="464 577 1414 873">Patient must be opioid free for a minimum of 7-10 days; AND Patient does not have a current need for opioid analgesics; AND Patient is using Vivitrol as part of a comprehensive treatment program for opioid dependence that should include a psychosocial support system; AND Patient has had a trial and failure, intolerance, or contraindication to ALL of the following: oral naltrexone, buprenorphine/naloxone SL tablets or films, AND buprenorphine SL tablets</p>

# NATAMYCIN

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## Products Affected

- NATACYN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Use as a single agent in fungal endophthalmitis.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	Patient has a documented diagnosis of fungal blepharitis, conjunctivitis, or keratitis caused by susceptible organisms including <i>Fusarium solani</i> keratitis confirmed by the clinical diagnosis, laboratory diagnosis by smear and culture of corneal scrapings and drug response.



# NEDOCROMIL

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## Products Affected

- ALOCRIL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO of the following: azelastine ophthalmic solution, cromolyn sodium ophthalmic solution, epinastine ophthalmic solution, olopatadine 0.1% ophthalmic solution

# NETUPITANT/PALONOSETRON

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## Products Affected

- AKYNZEO (NETUPITANT)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with contraindication to an antiemetic regimen that includes combination of a serotonin antagonist and dexamethasone.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an oncologist or hematologist.
<b>Coverage Duration</b>	6 months. IL: 12 months
<b>Other Criteria</b>	Patient will be using Akynzeo for the prevention of acute and/or delayed nausea and vomiting associated with chemotherapy; Patient will be using Akynzeo in combination with dexamethasone; AND Patient has had a trial and therapeutic failure to an antiemetic regimen including a combination of a serotonin antagonist and dexamethasone.

# NILOTINIB

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## Products Affected

- TASIGNA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	RESISTANT PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): BCR-ABL mutational analysis negative for the following mutations: T315I, Y253H, E255K/V, AND F359V/C/I.
<b>Age Restrictions</b>	NEWLY DIAGNOSED OR RESISTANT Ph+ CML IN CHRONIC PHASE: 1 year of age or older. RESISTANT Ph+ CML IN ACCELERATED PHASE: 18 years of age or older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# NILUTAMIDE

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## Products Affected

- *nilutamide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with severe hepatic impairment (baseline hepatic enzymes should be evaluated prior to treatment). Patients with severe respiratory insufficiency
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an oncologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

# NITAZOXANIDE

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## Products Affected

- ALINIA ORAL SUSPENSION FOR RECONSTITUTION
- *nitazoxanide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Prior hypersensitivity to nitazoxanide
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Tablets: 12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an infectious disease specialist.
<b>Coverage Duration</b>	Giardiasis or Cryptosporidiosis: 3 days
<b>Other Criteria</b>	A. GIARDIASIS (1) Prescriber attests patient has a diagnosis of diarrhea caused by <i>Giardia lamblia</i> (giardiasis) and (2) Patient is immunocompetent and is not infected with HIV and (3) Patient has had a trial and failure, contraindication, or intolerance to metronidazole. B. CRYPTOSPORIDIOSIS (1) Prescriber attests patient has a diagnosis of diarrhea caused by <i>Cryptosporidium parvum</i> (cryptosporidiosis) AND (2) Patient is immunocompetent and not infected with HIV

# OCTREOTIDE

## Products Affected

- *octreotide acetate* RECON
- SANDOSTATIN LAR DEPOT  
INTRAMUSCULAR  
SUSPENSION,EXTENDED REL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	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	<p>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.</p> <p>ADVANCED GERMLINE BRCA MUTATED OVARIAN CANCER: Medication will be used as monotherapy.</p> <p>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).</p>

# OLSALAZINE

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## Products Affected

- DIPENTUM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Known or suspected hypersensitivity to salicylates, aminosaliclates, or their metabolites
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by, or in conjunction with, a gastroenterologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of mild to moderate ulcerative colitis; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to ALL of the following (medication usage must be supported by documentation from the patients chart notes/medical records/electronic claim history): sulfasalazine (immediate-release/delayed-release), balsalazide, mesalamine ER capsules 0.37g (maintenance of remission)



# OMALIZUMAB

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## Products Affected

- XOLAIR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	NASAL POLYPS: 18 years of age or older. ASTHMA: 6 years of age or older. CIU: 12 years of age or older
<b>Prescriber Restrictions</b>	ASTHMA: Prescribed by or in consultation with a Pulmonologist, Immunologist, or Allergist.  CIU: Prescribed by an Allergist, Immunologist, or Dermatologist
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>Xolair is considered medically necessary for the following conditions:</p> <p>A. Nasal polyps in adult patients 18 years of age and older when the following criteria are met; both:</p> <ul style="list-style-type: none"> <li>a. Inadequate response to nasal corticosteroids</li> <li>b. Xolair will be utilized as add-on maintenance treatment</li> </ul> <p>B. Chronic idiopathic urticaria for member greater than 12 years of age; both:</p> <ul style="list-style-type: none"> <li>a. Unknown cause</li> <li>b. Unresponsive to H1 antihistamine treatment</li> </ul> <p>C. Moderate-to-severe, persistent asthma for members 6 years and older when the following criteria are met; all:</p> <ul style="list-style-type: none"> <li>a. Evidence of specific allergic sensitivity confirmed by positive skin test to perennial aeroallergens or RAST test</li> <li>b. Failure to respond to treatment for moderate, persistent asthma for greater than or equal to 6 months with either: <ul style="list-style-type: none"> <li>i. Moderate-dose ICS and long-acting beta-agonist</li> <li>ii. Low-moderate dose ICS, long-acting inhaled beta2-agonist, and leukotriene modifiers</li> </ul> </li> <li>c. Failure to respond to treatment for severe persistent asthma for greater than or equal to 6 months with high- dose ICS, long-acting inhaled beta2-agonist, and leukotriene modifiers</li> <li>d. IgE level greater than or equal 30 IU/mL to less than or equal to 1300 IU/mL for pediatric members between age 6 to less than 12 or IgE level less than or equal to 30 IU/mL to less than or equal to 700 IU/mL for members 12 years and older.</li> <li>e. Evidence of reversible disease (i.e., greater than or equal to 12% improvement in FEV1 following beta2-agonist administration</li> </ul>

# OSPEMIFENE

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## Products Affected

- OSPHENA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Undiagnosed abnormal genital bleeding. Known or suspected estrogen-dependent neoplasia. Active DVT, pulmonary embolism (PE), or a history of these conditions. Active arterial thromboembolic disease [for example, stroke and myocardial infarction (MI)], or a history of these conditions. Women who are or may become pregnant.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b>  Patient has a diagnosis of moderate to severe dyspareunia OR moderate to severe vaginal dryness, (symptoms of vulvar and vaginal atrophy), due to menopause; AND Patient has a documented trial and therapeutic failure, intolerance, or contraindication to <b>THREE</b> of the following (note: a woman with an intact uterus should use estrogen product with a progestin; a progestin is not needed if the woman has had a hysterectomy):</p> <p><b>A. Oral estrogen tablet</b></p> <ol style="list-style-type: none"> <li>1. Conjugated estrogen (e.g., Premarin)</li> <li>2. Esterified estrogen (e.g., Menest)</li> <li>3. Estradiol (e.g., Estrace)</li> <li>4. Estropipate</li> </ol> <p><b>B. Transdermal estrogen: Estradiol transdermal (e.g., Vivelle-Dot, Climara, Alora)</b></p> <p><b>C. Vaginal estrogen</b></p> <ol style="list-style-type: none"> <li>1. Conjugated estrogen cream (e.g., Premarin)</li> <li>2. Estradiol acetate cream (e.g., Estrace)</li> <li>3. Estradiol ring (e.g., Femring)</li> <li>4. Estradiol tablet (e.g., Vagifem)</li> </ol> <p><b>D. Esterfied estrogen-progestin oral tabs (e.g., Prempro, Premphase)</b></p> <p><b>E. Estrogen-progestin transdermal (e.g., Combipatch)</b></p> <p><b>F. Progestins if needed</b></p> <ol style="list-style-type: none"> <li>1. Medroxyprogesterone</li> <li>2. Micronized progesterone</li> </ol> <p><b>RENEWAL:</b>  Prescriber attests that patient is responding positively to therapy AND patient has not developed any FDA labeled contraindications.</p>

# OXICONAZOLE NITRATE CREAM

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## Products Affected

- *oxiconazole*

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	None
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of one of the following dermal infections: tinea pedis, tinea cruris, and tinea corporis due to <i>Trichophyton rubrum</i> , <i>Trichophyton mentagrophytes</i> , or <i>Epidermophyton floccosum</i> or tinea (pityriasis) versicolor due to <i>Malassezia furfur</i> AND Patient has a documented intolerance to, contraindication, or treatment failure to TWO of the following: clotrimazole 1% cream, econazole nitrate 1% cream, ciclopirox olamine 0.77% cream, or ketoconazole 2% cream.

# OXYCODONE EXTENDED RELEASE

## Products Affected

- *oxycodone oral tablet, oral only, ext. rel. 12 hr 10 mg, 20 mg, 40 mg* 20 MG, 30 MG, 40 MG
- OXYCONTIN ORAL TABLET, ORAL ONLY, EXT.REL.12 HR 10 MG, 15 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	A. SEVERE PAIN THAT REQUIRES AN OPIOID ANALGESIC OR CHRONIC SEVERE PAIN IN OPIOID-TOLERANT PATIENTS REQUIRING A LONG-TERM DAILY AROUND-THE-CLOCK OPIOID ANALGESIC (1) Prescriber attests patient has diagnosis of Severe pain that requires an opioid analgesic or Chronic, severe pain in opioid-tolerant patients requiring a long-term daily around-the-clock opioid analgesic (2) One of the following: (i) Member has had a trial and inadequate clinical response or intolerance to two preferred short acting agents (Oxycodone tablet, morphine sulfate tablet, oxycodone/APAP, hydromorphone) (ii) Patient has a need for an abuse-deterrent formulation based upon a history of substance abuse disorder by dissolving in order to inject or snorting (iii) Patient has a need for an abuse-deterrent formulation based upon household resident has active substance abuse disorder or a history of substance use disorder

# OXYMORPHONE EXTENDED RELEASE

## Products Affected

- *oxymorphone oral tablet extended release*  
12 hr

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Moderate and severe hepatic impairment, Paralytic ileus
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	A. CHRONIC PAIN (1) used for management of moderate-to-severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time AND (2) not intended for use as a prn analgesic AND (3) trial/failure to ALL of the opioids (hydrocodone/APAP, morphine IR, oxycodone IR, hydromorphone IR, morphine ER) (documentation required) AND (4) An inadequate response, intolerance, or contraindication to both of the following (documentation required): Hysingla ER AND Oxycontin AND (5) Patient has been warned that: Co-administration with alcohol may increase oxymorphone plasma levels and the risk of potentially fatal toxicity AND Opana should be taken on an empty stomach since food can increase the rate of absorption by 50%

# PALBOCICLIB

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## Products Affected

- IBRANCE

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



# PALIPERIDONE

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## Products Affected

- INVEGA SUSTENNA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to risperidone
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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. For Invega Sustenna, patient has documented issues with compliance and long-acting injection is clinically necessary.

# PALIPERIDONE TAB ER

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## Products Affected

- *paliperidone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to risperidone
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. Any indication other than those listed in Other Criteria due to insufficient evidence of therapeutic value</li> <li>2. Infants with cardiac lesions adequately corrected by surgery (unless pharmacological management is required for CHF)</li> <li>3. Infants with CLD not requiring medical support in the 2nd year of life</li> <li>4. Infants with mild cardiomyopathy, which does not require pharmacotherapy</li> <li>5. Synagis use as routine prophylaxis for any of the following conditions:               <ol style="list-style-type: none"> <li>a. Down syndrome (unless qualifying heart disease, CLD/BPD, airway clearance issues or prematurity [less than 29 weeks, 0 days gestation] is present)</li> <li>b. Nosocomial disease prevention</li> <li>c. Primary asthma prevention (or for reduction of subsequent wheezing episodes) in infants and children</li> </ol> </li> <li>6. Synagis use as prophylaxis in any of the following scenarios:               <ol style="list-style-type: none"> <li>a. Outside of RSV "season" as defined by Centers for Disease and Prevention (CDC) surveillance reports or state or local health departments</li> <li>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</li> <li>c. Monthly Synagis administration as prophylaxis post breakthrough RSV hospitalization during the current season (if child had met criteria for palivizumab)</li> </ol> </li> <li>7. Treatment of symptomatic RSV disease</li> </ol>
<b>Required Medical Information</b>	See Other Criteria
<b>Age Restrictions</b>	See Other Criteria

PA Criteria	Criteria Details
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Max 5 months of Synagis (15 mg/kg body weight per dose) w/ last dose given in March or per CDC
<b>Other Criteria</b>	<p>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:</p> <ol style="list-style-type: none"> <li>1. Early Preterm Infants <ol style="list-style-type: none"> <li>a. Infants born before 29 weeks, 0 days gestation and younger than 12 months of age at the start of RSV season</li> </ol> </li> <li>2. Chronic Lung Disease of Prematurity (CLD)/Bronchopulmonary dysplasia (BPD) <ol style="list-style-type: none"> <li>a. Infants younger than 12 months of age at the start of RSV season: <ol style="list-style-type: none"> <li>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)</li> <li>b. Infants between 12 : 24 months of age at the start of RSV season: <ol style="list-style-type: none"> <li>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 child's second RSV season</li> </ol> </li> </ol> </li> </ol> </li> <li>3. Hemodynamically significant Congenital Heart Disease (CHD) <ol style="list-style-type: none"> <li>a. Infants younger than 24 months of age at the start of RSV season with one of the following: <ol style="list-style-type: none"> <li>i. Acyanotic heart disease who are receiving medication to control congestive heart failure (CHF) AND will require cardiac surgical procedures</li> <li>ii. Cyanotic heart defects</li> <li>iii. Moderate to severe pulmonary hypertension</li> <li>iv. Will undergo cardiac transplantation during RSV season</li> </ol> </li> </ol> </li> <li>4. Anatomic Pulmonary Abnormalities or Neuromuscular Disorder <ol style="list-style-type: none"> <li>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</li> </ol> </li> <li>5. Immunocompromised status</li> </ol>

PA Criteria	Criteria Details
	<p>a. Infants younger than 24 months of age at the start of RSV season and are profoundly immunocompromised during the RSV season</p> <p>i. Examples of severe immunodeficiencies are:</p> <ol style="list-style-type: none"> <li>1. Severe combined immunodeficiency</li> <li>2. Severe acquired immunodeficiency syndrome</li> <li>3. Acute myeloid leukemia / acute lymphoblastic leukemia</li> <li>4. Chemotherapy</li> <li>5. Solid organ or hematopoietic stem cell transplant recipients</li> <li>6. Cystic Fibrosis:</li> </ol> <p>a. Infants younger than 12 months of age at the start of RSV season:</p> <p>i. With clinical evidence of CLD/BPD and/or nutritional compromise</p> <p>b. Infants between 12:24 months of age at the start of RSV season:</p> <p>i. For second year treatment, infant has manifestations of severe lung disease including one of the following:</p> <ol style="list-style-type: none"> <li>1. Previous hospitalization for pulmonary exacerbation in the first year of life</li> <li>2. Abnormalities on chest radiography or chest computed tomography that persist when stable</li> <li>3. Weight for length less than the 10th percentile on a pediatric growth chart</li> </ol>

# PANOBINOSTAT

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## Products Affected

- FARYDAK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	RENEWAL: Tolerated the first 8 cycles of therapy without any severe or medically significant toxicity

# PARICALCITOL

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## Products Affected

- *paricalcitol oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Hypercalcemia Vitamin D toxicity
<b>Required Medical Information</b>	<b>SECONDARY HYPERPARATHYROIDISM</b> 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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p><b>SECONDARY HYPERPARATHYROIDISM INITIAL</b></p> <p>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.</p>



# PAROXETINE SUSPENSION

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## Products Affected

- *paroxetine hcl oral suspension*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients taking, or within 14 days of stopping, MAOIs (including the MAOIs linezolid and intravenous methylene blue). Concurrent use of thioridazine or pimozide. Known hypersensitivity to paroxetine.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic oral paroxetine; AND Patient is unable to ingest solid oral dosage forms due to one of the following: Oral/motor difficulties; OR Dysphagia.

# PASIREOTIDE DIASPARTATE

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## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 months. IL: 12 months
<b>Other Criteria</b>	INITIAL: Trial of or contraindication to oral ketoconazole.  RENEWAL: (1) Continued improvement of Cushings disease (e.g., clinically meaningful reduction in 24-hour urinary free cortisol and/or improvements in signs and symptoms of disease). (2) Maintains tolerability to Signifor.

# PASIREOTIDE PAMOATE

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## Products Affected

- SIGNIFOR LAR

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	Prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	<p>ACROMEGALY: Patient has had an inadequate response to surgery OR surgery is not an option; AND Patient has had an inadequate response, intolerance, or contraindication to Lanreotide depot injection (Somatuline Depot) AND a dopamine agonist (e.g., bromocriptine, cabergoline).</p> <p>CUSHINGS DISEASE: Patient has had an inadequate response to surgery OR surgery is not an option.</p>

# PAZOPANIB

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## Products Affected

- VOTRIENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patient has adipocytic soft tissue sarcoma (STS) or gastrointestinal stromal tumors (GIST)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# PCSK9

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None

PA Criteria	Criteria Details
<p><b>Required Medical Information</b></p>	<p><b>INITIAL:</b>  <b>HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH):</b>  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.  <b>HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HoFH):</b>  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.  <b>CLINICAL ASCVD OR PRIMARY HYPERLIPIDEMIA AT HIGH RISK FOR ASCVD:</b></p>
	<p>(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.</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Age Restrictions</b>	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.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
<b>Coverage Duration</b>	INITIAL: 12 months, RENEWAL: 12 months

PA Criteria	Criteria Details
Other Criteria	<p>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.</p> <p>HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (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.</p> <p>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</p>



PA Criteria	Criteria Details
	<p>AND (b) in combination with ezetimibe</p> <p><b>RENEWAL: ALL INDICATIONS:</b></p> <p>(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.</p>

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	REVATIO/SILDENAFIL: 18 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or given in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	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

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## Products Affected

- NYVEPRIA
- ZIEXTENZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL: HEPATITIS B: Cirrhosis
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	HEPATITIS B: 3 years of age or older HEPATITIS C: 3 to 11 years of age
<b>Prescriber Restrictions</b>	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.  HEPATITIS 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)
<b>Coverage Duration</b>	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
<b>Other Criteria</b>	<p><b>INITIAL:</b>  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.</p> <p><b>RENEWAL:</b>  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</p>

# PEGVISOMANT

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## Products Affected

- SOMAVERT

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	ACROMEGALY: INITIAL: Prescriber must provide the following baseline documentation from patient's medical record: (i) Elevated serum IGF-1 level for patients age range and gender ACROMEGALY: RENEWAL: Patient has documented disease response confirmed by reduction of IGF-I blood levels from baseline. AND Serum insulin-like growth factor-I (IGF-I) levels remain outside normal limits.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	ACROMEGALY: INITIAL: Patient has a diagnosis of Acromegaly; AND Patient has had an inadequate response to surgery or radiation therapy, or documentation that these therapies are not appropriate.

# PEMETREXED

## Products Affected

- ALIMTA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	History of severe hypersensitivity reaction to pemetrexed. Diagnosis of squamous cell non-small cell lung cancer.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>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.</p> <p>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.</p>

# PENICILLAMINE

## Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p><b>INITIAL:</b>  <b>WILSONS DISEASE:</b> 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  <b>CYSTINURIA:</b> Daily cystine output greater than 300mg per 24 hours following urine cystine excretion testing</p> <p><b>RENEWAL:</b>  <b>WILSONS DISEASE:</b> Free serum copper level less than 10 mcg/dL  <b>CYSTINURIA:</b> Cystine excretion of less than 200 mg/day</p>
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	<p><b>WILSONS DISEASE:</b> Prescribed by or given in consultation with a hepatologist</p> <p><b>CYSTINURIA:</b> Prescribed by or given in consultation with a nephrologist</p> <p><b>RHEUMTATOID ARTHRITIS (RA):</b> Prescribed by or given in consultation with a rheumatologist</p>
<b>Coverage Duration</b>	<p><b>INITIAL:</b> 12 months  <b>RENEWAL:</b> Lifetime</p>



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b> Request for D-Penaminate may be approved without additional criteria met if patient has an active prior authorization approval for Depen: [Note: D-Penaminate 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.]</p> <p><b>WILSONS DISEASE:</b> (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-Penaminate (penicillamine)</p> <p><b>CYSTINURIA:</b> (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 alkalization. (3) Requests for Cuprimine require trial of or contraindication to Depen (penicillamine) or D-Penaminate (penicillamine) AND Thiola (tiopronin)</p> <p><b>RA:</b> (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-Penaminate</p>
	<p><b>RENEWAL:</b> <b>RA:</b> 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</p>

# PENTOSAN POLYSULFATE

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## Products Affected

- ELMIRON

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

# PERAMPANEL

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## Products Affected

- FYCOMPA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Primary Generalized Tonic-Clonic Seizures: 12 years of age or older, Partial-onset seizures: 4 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of partial-onset seizures; AND (2) Patient has had a trial and failure, intolerance, or contraindication to at least TWO (2) antiepileptic drugs; OR History Vagal Nerve Stimulator (VNS) implantation or lobectomy; OR Patient has a diagnosis of primary generalized tonic-clonic seizures; AND Patient has had a trial and failure, intolerance, or contraindication to valproate (Depakote, Depakote ER, Depakene); AND Patient will be using Fycompa in combination with other antiepileptic medications

# PHENOXYBENZAMINE

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## Products Affected

- *phenoxybenzamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist, an endocrine surgeon, or a hematologist/oncologist
<b>Coverage Duration</b>	21 days
<b>Other Criteria</b>	(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

- *lanthanum*
- *sevelamer carbonate oral powder in packet*
- *sevelamer hcl*
- VELPHORO

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Sevelamer carbonate/sevelamer HCl/lanthanum carbonate: Patients with bowel obstruction. Sevelamer carbonate ONLY: Patients with known hypersensitivity to sevelamer carbonate or sevelamer hydrochloride.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Sevelamer carbonate: 6 years of age and older. All others: 18 years of age and older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

# PIMECROLIMUS

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## Products Affected

- *pimecrolimus*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(1) Diagnosis of mild to moderate atopic dermatitis AND (2) Patient is not immunocompromised AND (3) Patient had a documented trial and failure, intolerance, or contraindication to at least ONE formulary topical corticosteroid (e.g., hydrocortisone, amcinonide, betamethasone, clobetasol, desoximetasone, fluocinolone, triamcinolone) OR (4) Elidel will be used on the face, body skin folds, genital area, armpit, or around the eyes AND (5) Patient has had a documented trial and failure, intolerance, or contraindication to tacrolimus ointment.

# PIRFENIDONE

## Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 801 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	INITIAL: (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

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## Products Affected

- PHENEX-1
- PHENEX-2

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



# PLECANATIDE

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## Products Affected

- TRULANCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	SEVERE CHRONIC IDIOPATHIC CONSTIPATION AND IRRITABLE BOWEL SYNDROME WITH CONSTIPATION (1) Prescriber attests patient has diagnosis of Severe Chronic Idiopathic Constipation or Irritable Bowel Syndrome with Constipation (2) Trial and failure, intolerance, or contraindication to Linzess (3) An inadequate response to at least one agent from within each of the following laxative types: (i) Fiber laxatives (psyllium, methylcellulose, calcium polycarbophil) (ii) Stimulant laxatives (bisacodyl, Senna) (iii) Osmotic laxatives (polyethylene glycol, milk of magnesia, sorbitol, lactulose)

# POMALIDOMIDE

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## Products Affected

- POMALYST

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

# PONATINIB

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## Products Affected

- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG

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

# POSACONAZOLE

## Products Affected

- *posaconazole oral tablet, delayed release (drlec)*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Known hypersensitivity to posaconazole or other azole antifungal agents. Concomitant administration of sirolimus, ergot alkaloids (ergotamine and dihydroergotamine), HMG-CoA reductase inhibitors (e.g., atorvastatin, lovastatin, and simvastatin), CYP3A4 substrates that prolong the QT interval (e.g., pimozide and quinidine).
<b>Required Medical Information</b>	TREATMENT OF INVASIVE ASPERGILLUS Patient has diagnosis of clinically documented invasive aspergillosis, that is susceptible to posaconazole confirmed by fungal culture and other relevant laboratory studies (including histopathology) with isolated and identified causative organisms
<b>Age Restrictions</b>	INVASIVE ASPERGILLOSIS: 13 years of age and older PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTIONS: adults and pediatric patients 2 years of age and older who weigh greater than 40 kg
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an infectious disease specialist.
<b>Coverage Duration</b>	Treatment of invasive Aspergillosis: 3 months All others: 1 month
<b>Other Criteria</b>	TREATMENT OF INVASIVE ASPERGILLUS: Patient has had a trial and therapeutic failure of voriconazole AND amphotericin B. PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTIONS: Patient is recipient of hematopoietic stem cell transplant (HSCT) with Graft-vs-Host Disease (GVHD) and who is at risk of developing invasive Aspergillus fumigatus and/or Candida infections OR (2) Patient has hematological malignancies causing prolonged neutropenia from chemotherapy and who is at risk of developing Aspergillus fumigatus and/or Candida infections

# PRAMLINTIDE

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## Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypoglycemia unawareness. Confirmed gastroparesis.
<b>Required Medical Information</b>	Hgb A1C
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient utilizes both basal and short-acting insulin OR Patient uses an insulin pump; AND Patient has failed to achieve desired glucose control despite optimal insulin therapy.

# PRASTERONE

## Products Affected

- INTRAROSA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Undiagnosed abnormal genital bleeding.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL: 3 months. RENEWAL: 12 months IL: 12 months
<b>Other Criteria</b>	<p><b>INITIAL:</b>            Patient has a diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause; AND Patient has tried and failed two vaginal lubricants or vaginal moisturizers; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to a 4 week trial of two vaginal estrogen products (e.g., Estrace vaginal cream, Premarin vaginal cream, Vagifem, Estring).</p> <p><b>RENEWAL:</b>            Patient has had a response to therapy (decrease in symptoms of dyspareunia) as determined by prescriber.</p> <p>INITIAL/RENEWAL: Dose must not exceed 1 vaginal insert daily</p>

# PREDNISOLONE-GENTAMICIN OPHTHALMIC

## Products Affected

- PRED-G
- PRED-G S.O.P.

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Fungal disease of ocular structure. Mycobacterial infection of the eye. Viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella. Suspected or known hypersensitivity to Pred-G or any of its ingredients or to other corticosteroids.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	30 days.
<b>Other Criteria</b>	Patient has a diagnosis of steroid-responsive inflammatory ocular condition for which a corticosteroid is indicated where superficial bacterial ocular infection or risk of bacterial ocular infection exists; AND Patient has a documented intolerance, contraindication, or treatment failure with, an adequate trial of TWO of the following: Tobramycin/dexamethasone ophthalmic suspension OR Tobradex ointment Neomycin/polymyxin B/dexamethasone ophthalmic Suspension OR Ointment Neomycin/polymyxin B/hydrocortisone ophthalmic Suspension OR Ointment Sulfacetamide-prednisolone ophthalmic solution OR Blephamide S.O.P. ophthalmic ointment

# PROCARBAZINE

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## Products Affected

- MATULANE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with inadequate marrow reserve as demonstrated by bone marrow aspiration.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a Hematologist or Oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of Stage III and IV Hodgkins disease; AND Matulane will be used as part of the MOPP (nitrogen mustard, vincristine, procarbazine, prednisone) regimen.



# PROGESTERONE (4%)

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## Products Affected

- CRINONE

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/RENEWAL:12 months
Other Criteria	<p>INITIAL: SECONDARY AMENORRHEA: (1) Prescriber attests to diagnosis of secondary amenorrhea AND (2) Clinical trial and failure to one alternative progestin (e.g., medroxyprogesterone, norethindrone) unless contraindicated or clinically significant adverse effects are experienced.</p> <p>RENEWAL: SECONDARY AMENORRHEA: (1) Currently receiving medication via health plan benefit or member has previously met initial approval criteria AND (2) Prescriber attests to a positive response to therapy.</p>

# PROGESTERONE (8%)

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## Products Affected

- CRINONE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications unless otherwise excluded from benefit . Prevention of preterm birth will also be considered for approval.
<b>Exclusion Criteria</b>	Diagnoses excluded from benefit.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL:12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b>  <b>SECONDARY AMENORRHEA:</b> (1) Prescriber attests to diagnosis of secondary amenorrhea (2) Clinical trial and failure to one alternative progestin (e.g., medroxyprogesterone, norethindrone) unless contraindicated or clinically significant adverse effects are experienced</p> <p><b>PREVENTION OF PRETERM BIRTH:</b> (1) Prescriber attests that this is used in prevention of preterm birth (2) Documentation of one of the following (2a) short cervix OR (2b) Singleton pregnancy and a history of spontaneous preterm birth</p> <p><b>LUTEAL PHASE SUPPORT (I.E. HISTORY OF SPONTANEOUS ABORTIONS):</b> (1) Prescriber attests to this being used in luteal phase support</p> <p><b>RENEWAL:</b>  Currently receiving medication via health plan benefit or member has previously met initial approval criteria AND (2) Request is for Crinone 8% AND (3) Prescriber attests to a positive response to therapy</p> <p><b>FERTILITY COVERAGE DEPENDENT UPON BENEFIT COVERAGE (Not covered by plan if fertility is an excluded benefit): ASSISTED REPRODUCTIVE TECHNOLOGY (ART) TREATMENT:</b> (1) Must meet one of the following (1a) Use as ART treatment for infertile women with progesterone deficiency OR (1b) Use in ART treatment in patients with partial or complete ovarian failure OR (1c) For support embryo implantation and early pregnancy by supplementation of corpus luteal function as part of an ART treatment program for infertile women</p>

# PYRAZINAMIDE

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## Products Affected

- *pyrazinamide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with severe hepatic damage Patients with acute gout
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an Infectious Disease specialist
<b>Coverage Duration</b>	2 months
<b>Other Criteria</b>	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

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## Products Affected

- *pyridostigmine bromide oral syrup*

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

# PYRIMETHAMINE

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## Products Affected

- *pyrimethamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Toxoplasmosis (Treatment and prophylaxis). Pneumocystis Pneumonia (primary and secondary prophylaxis).
<b>Exclusion Criteria</b>	Patients with documented megaloblastic anemia due to folate deficiency
<b>Required Medical Information</b>	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/mm <sup>3</sup> if initiating prophylaxis OR CD4 less than 100-200 cells/mm <sup>3</sup> if reinstating prophylaxis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	PRIMARY PROPHYLAXIS: 6 mo. TREATMENT AND SECONDARY PROPHYLAXIS: 12 mo.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>TOXOPLASMOSIS Chart notes/medical records required for all of the below.</p> <p>(1) Patient has a documented diagnosis of active severe acquired toxoplasmosis (including toxoplasmic encephalitis and congenital toxoplasmosis); OR</p> <p>(2) Pyrimethamine is being used for secondary prophylaxis of toxoplasmic encephalitis; OR</p> <p>(3) Pyrimethamine is being used for primary prophylaxis for toxoplasmic encephalitis; AND</p> <p>3a) pyrimethamine will be used in combination with dapsone or atovaquone; AND</p> <p>3b) Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP- SMX); AND</p> <p>3c) Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate; OR</p> <p>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).</p> <p>PNEUMOCYSTIS PNEUMONIA (PCP)</p> <p>(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).</p>

# RANOLAZINE

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## Products Affected

- *ranolazine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Concurrent use with strong inhibitors of CYP3A and inducers of CYP3A Patients with clinically significant hepatic impairment
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a cardiologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has diagnosis of Chronic Angina; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to ALL of the following at maximum tolerated dosages (medication usage must be supported by documentation from the patients chart notes/medical records/electronic claim history): calcium channel blocker, beta-blocker, nitrate.



# RETAPAMULIN

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## Products Affected

- ALTABAX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	9 months of age and older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months.
<b>Other Criteria</b>	Patient has a diagnosis of impetigo; AND Patient has a documented intolerance, contraindication, or treatment failure with, an adequate trial of mupirocin 2% ointment

# RIBOCICLIB

## Products Affected

- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

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	<p><b>KISQALI-FEMARA CO-PACK:</b>            Patient has not experienced disease progression following prior CDK inhibitor therapy            If request is for post-menopausal patient: Trial of Ibrance (palbociclib) or Verzenio (abemaciclib) is required.</p> <p><b>KISQALI:</b>            Patient has not experienced disease progression following prior CDK inhibitor therapy            If request is for use in combination with an aromatase inhibitor in post-menopausal patient: Trial of Ibrance (palbociclib) or Verzenio (abemaciclib) is required.            If request is for use in combination with Faslodex (fulvestrant) after disease progression on endocrine therapy in post-menopausal patient: Trial of Ibrance (palbociclib) or Verzenio (abemaciclib) is required.</p>

# RIFABUTIN

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## Products Affected

- *rifabutin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Hypersensitivity to rifabutin or to any other rifamycins.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	Initial: Patient has diagnosis of advanced HIV infection; Patient requires MAC prophylaxis confirmed by documented CD4+ count remains less than 100 cells/mcL; AND For primary prophylaxis patient has had a trial and failure, intolerance, or contraindication to both clarithromycin and azithromycin; OR For secondary prophylaxis, rifabutin will be used in combination with ethambutol plus clarithromycin or azithromycin. Renewal: Patients CD4+ count remains less than 100 cells/mcL

# RIFAXIMIN

## Products Affected

- XIFAXAN ORAL TABLET 200 MG,  
550 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications. Xifaxan 200mg: Hepatic encephalopathy (HE), Clostridium difficile infection (CDI)
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	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
<b>Other Criteria</b>	<p><b>INITIAL:</b>  <b>HEPATIC ENCEPHALOPATHY:</b> 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.  <b>IRRITABLE BOWEL SYNDROME WITH DIARRHEA:</b> (1) Trial of or contraindication to tricyclic anti-depressants or dicyclomine, AND (2) Request is for Xifaxan 550mg tablets.  <b>TRAVELERS DIARRHEA:</b> (1) Trial of or contraindication to oral azithromycin, ciprofloxacin, ofloxacin, or levofloxacin, AND (2) Request is for Xifaxan 200mg tablets.  <b>CLOSTRIDIUM DIFFICILE INFECTION:</b> (1) Had at least one previous occurrence of Clostridium difficile infection, AND (2) Use in combination with vancomycin.</p> <p><b>RENEWAL:</b>  <b>HEPATIC ENCEPHALOPATHY:</b> Request is for Xifaxan 550mg tablets.  <b>IRRITABLE BOWEL SYNDROME WITH DIARRHEA:</b> 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</p>

# RILONACEPT

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## Products Affected

- ARCALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	CAPS/Pericarditis: 12 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a rheumatologist or immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# RIMEGEPANT

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## Products Affected

- NURTEC ODT

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b>  <b>ACUTE MIGRAINE TREATMENT:</b> Trial of or contraindication to ONE triptan (e.g., sumatriptan, rizatriptan).  <b>EPISODIC MIGRAINE PREVENTION:</b> 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.</p> <p><b>RENEWAL:</b>  <b>ACUTE MIGRAINE TREATMENT:</b> 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.  <b>EPISODIC MIGRAINE PREVENTION:</b> 1) Reduction in migraine or headache frequency of at least 2 days per month, OR 2) Reduction in migraine severity or migraine duration.</p>



# RIOCIQUAT

## Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	<p>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.</p> <p>CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4: INITIAL: NYHA-WHO functional class II-IV Symptoms.</p>
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
<b>Other Criteria</b>	<p><b>INITIAL:</b>  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.</p> <p><b>RENEWAL: PAH/CTEPH:</b>  (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.</p>

# RISANKIZUMAB-RZAA

## Products Affected

- SKYRIZI

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	PsO: Prescribed by or in consultation with a dermatologist. PsA: Prescribed by or in consultation with a rheumatologist or dermatologist
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months IL: 12 months
<b>Other Criteria</b>	<p>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.</p> <p>PsA: trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine</p> <p>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.</p> <p>PsA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy</p>

# ROLAPITANT

## Products Affected

- VARUBI ORAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients taking CYP2D6 substrates with a narrow therapeutic index, such as thioridazine and pimoziide.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months IL: 12 months
<b>Other Criteria</b>	<p>Patient is using Varubi for prevention of delayed nausea and vomiting AND Patient is receiving highly or moderately emetogenic chemotherapy (see HEC/MEC list below); AND Patient is using Varubi in combination with a 5-HT3 receptor antagonist such as ondansetron or granisetron; AND Patient is using Varubi in combination with a corticosteroid such as dexamethasone.</p> <p>Highly Emetogenic Chemotherapy (HEC) includes: Carboplatin, Carmustine, Cisplatin, Cyclophosphamide, Dacarbazine, Doxorubicin, Epirubicin, Ifosfamide, Mechlorethamine, Streptozocin.</p> <p>Moderately Emetogenic Chemotherapy (MEC) includes: Aldesleukin, Amifostine, Arsenic Trioxide, Azacitidine, Bendamustine, Busulfan, Clofarabine, Cytarabine, - Dactinomycin, Daunorubicin, Dinutuximab, Idarubicin, Interferon alfa, Irinotecan, Melphalan, Methotrexate, Oxaliplatin, Temozolomide, Trabectedin</p> <p>The following regimens can be considered HEC: FOLFOX.</p>

# ROTIGOTINE

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## Products Affected

- NEUPRO

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

# RUXOLITINIB

## Products Affected

- JAKAFI

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	INTERMEDIATE OR HIGH-RISK MYELOFIBROSIS, POLYCYTHEMIA VERA: 18 years of age or older. STEROID-REFRACTORY ACUTE GRAFT-VERSUS-HOST DISEASE, CHRONIC GRAFT-VERSUS-HOST DISEASE: 12 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	MYELOFIBROSIS: INIT: 6 mo. RNWL: 12 mo. PV, ACUTE GvHD, CHRONIC GvHD: 12 mo. IL: 12 mo
<b>Other Criteria</b>	POLYCYTHEMIA VERA: INITIAL: Trial of or contraindication to hydroxyurea.  MYELOFIBROSIS: RENEWAL: Patient shows symptom improvement by meeting ONE of the following: (1) 50% or greater reduction in total symptom score (such as Myeloproliferative Neoplasm Symptom Assessment Form [MPN-SAF TSS], modified Myelofibrosis Symptom Assessment Form [MFSAF] v2.0), (2) 50% or greater reduction in spleen length, OR (3) spleen volume reduction of 35% or greater from baseline.

# SARGRAMOSTIM

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## Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	ACUTE MYELOID LEUKEMIA FOLLOWING INDUCTION CHEMOTHERAPY: 55 years of age or older. AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL MOBILIZATION AND COLLECTION: 18 years of age or older. AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL AND BONE MARROW TRANSPLANTATION: 2 years of age or older. ALLOGENEIC OR AUTOLOGOUS BONE MARROW TRANSPLANTATION: 2 years of age or older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months or requested duration of treatment up to 1 year
<b>Other Criteria</b>	Leukine requests prescribed by or given in consultation with a hematologist or oncologist are excepted from the PA criteria.

# SECUKINUMAB

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months



PA Criteria	Criteria Details
Other Criteria	<p><b>INITIAL:</b></p> <p><b>PsO:</b> 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.</p> <p><b>PsA:</b> (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</p> <p><b>AS:</b> (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.</p> <p><b>nr-axSpA:</b> Trial of or contraindication to an NSAID (e.g., ibuprofen, naproxen, meloxicam, diclofenac, etc.)</p> <p><b>ERA:</b> Trial of or contraindication to an NSAID (e.g., ibuprofen, naproxen, meloxicam, diclofenac, etc.), sulfasalazine, OR methotrexate</p> <p><b>RENEWAL:</b></p> <p><b>PsO:</b> 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.</p> <p><b>PsA:</b> Patient experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.</p> <p><b>AS/nr-axSpA:</b> 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</p> <p><b>ERA:</b> Patient has experienced or maintained an improvement in global assessment of disease activity, functional ability, number of</p>
	joints with active arthritis, OR number of joints with limited range of motion

# SELEXIPAG

## Products Affected

- UPTRAVI ORAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	INITIAL: (1) Documented confirmatory pulmonary arterial hypertension (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. (2) NYHA-WHO Functional Class II-IV symptoms.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months
<b>Other Criteria</b>	<p>INITIAL:</p> <p>WHO FUNCTIONAL CLASS II OR III SYMPTOMS: Trial or contraindication to TWO agents from the following different drug classes: 1) Oral endothelin receptor antagonist, 2) Oral phosphodiesterase-5 inhibitor, 3) Oral cGMP stimulator.</p> <p>WHO FUNCTIONAL CLASS III SYMPTOMS WITH EVIDENCE OF RAPID PROGRESSION/POOR PROGNOSIS, OR WHO FUNCTIONAL CLASS IV SYMPTOMS: Trial or contraindication to ONE intravenous or subcutaneous prostacyclin.</p> <p>RENEWAL: (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.</p>

# SELINEXOR

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## Products Affected

- XPOVIO ORAL TABLET 60MG  
TWICE WEEK (120 MG/WEEK)

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

# SERTACONAZOLE NITRATE

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## Products Affected

- ERTACZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a documented diagnosis of interdigital tinea pedis caused by <i>Trichophyton rubrum</i> , <i>Trichophyton mentagrophytes</i> , or <i>Epidermophyton floccosum</i> ; AND Patient is not immunocompromised; AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to TWO (2) of the following: clotrimazole 1% cream, econazole nitrate 1% cream, or ketoconazole 2% cream

# SILODOSIN

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## Products Affected

- *silodosin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Severe renal impairment (CCr less than 30 mL/min) Severe hepatic impairment (Child-Pugh score greater than 10) Concomitant administration with strong Cytochrome P450 3A4 (CYP3A4) inhibitors (e.g., ketoconazole, clarithromycin, itraconazole, ritonavir)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has diagnosis of Benign Prostatic Hyperplasia (BPH); AND Patient has had a trial and failure, contraindication, or intolerance to at least TWO of the following: (i) tamsulosin (ii) doxazosin (iii) alfuzosin (iv) terazosin.

# SIROLIMUS

## Products Affected

- *sirolimus*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	LYMPHANGIOLEIOMYOMATOSIS (LAM): Prescriber attests patient has diagnosis of Lymphangiomyomatosis (LAM) confirmed by lung biopsy or HRCT showing cystic lung disease
<b>Age Restrictions</b>	LAM: 18 years of age or older
<b>Prescriber Restrictions</b>	RENAL TRANSPLANT: Prescribed by or in consultation with a transplant specialist. LAM: Prescribed by, or in consultation with, a pulmonologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>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</p> <p>LYMPHANGIOLEIOMYOMATOSIS (LAM): Patient has one of the following conditions: (i) Diagnosis of Tuberous Sclerosis Complex (TSC) (ii) Chylous Pleural Effusion (iii) Angioleiomyoma</p>

# SOFOSBUVIR

## Products Affected

- SOVALDI ORAL TABLET

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<p>(1) Severe renal impairment (eGFR less than 30 mL/min), ESRD, or req. dialysis. (2) Lim. life expect (less than 12 mo.) due to non-liver related comorbid conditions. (3) Currently taking: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, or tipranavir/ritonavir. (4) Using Sovaldi with direct antiviral (e.g., Olysio or Daklinza) AND concurrently taking amiodarone. (5) Adult with compensated cirrhosis. (6) Adult taking Sovaldi with ribavirin OR peginterferon alfa and ribavirin. (7) Solvadi plus Daklinza combo: currently (C/I or not recommended by the manufacturer, except specified HIV medications): amiodarone, carbamazepine, phenytoin, rifampin, or rifapentine. (8) Sovaldi plus Olysio combo: Any of: a) Has cirrhosis, b) Completed prior full course of therapy with i) any HCV protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), or Victrelis (boceprevir)] and has not achieved a sustained virologic response (SVR) OR ii) regimen containing NS5A inhibitor (e.g., Harvoni, Epclusa, Technivie, Viekira Pak or Viekira XR, Zepatier, or Daklinza-containing regimen), c) Concurrently using any of the following with Sovaldi/Olysio which are not recommended by the manufacturer of Olysio: i) Carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, erythromycin (not topical), clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole (not topical), voriconazole, dexamethasone, cisapride, cyclosporine, rosuvastatin above 10mg, or atorvastatin above 40mg, ii) Any of the following HIV meds: delavirdine, etravirine, nevirapine, or efavirenz, iii) Cobicistat-containing meds (e.g., Stribild or Genvoya, Evotaz, Prezcobix, or Tybost), iv) HIV protease inhibitor (e.g., atazanavir, fosamprenavir, lopinavir, indinavir, nelfinavir, saquinavir, tipranavir, ritonavir, or darunavir/ritonavir.</p>
<b>Required Medical Information</b>	Chronic HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Age Restrictions</b>	Genotype 1: 18 years of age or older Genotype 2: 3 to 17 years of age or older Genotype 3: 3 years of age or older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	Coverage duration will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	<p>(1) Criteria will be applied consistent with current AASLD/IDSA guidance.</p> <p>(2) Sovaldi will be used with Olysio (genotype 1 only) or Daklinza (genotype 1 or 3 only) for adult patients (greater than or equal 18 years).</p> <p>(3) Sovaldi will be used together with ribavirin (genotypes 2 and 3) for pediatric patients (less than 18 years).</p> <p>(3) For patients 18 years of age or older: Short trial of or contraindication to the preferred formulary agent(s) as follows: a) Genotype 1, Epclusa or Harvoni, b) Genotype 3, Epclusa.</p> <p>(4) Sovaldi plus Daklinza combination regimen: Will be taking ribavirin together with Sovaldi and Daklinza if has decompensated cirrhosis or post-liver transplant.</p> <p>(5) Sovaldi plus Olysio combination regimen: Previously failed a full course of therapy with a) any hepatitis c virus protease inhibitor (type of Hep C drug such as Incivek [telaprevir], Olysio [simeprevir], or Victrelis [boceprevir), OR b) a regimen containing NS5A inhibitor (type of hepatitis medication such as Harvoni, Epclusa, Technivie, Viekira Pak or Viekira XR, Zepatier, or Daklinza-containing regimen.</p>



# SOFOBUVIR/VELPATASVIR

## Products Affected

- EPCLUSA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	(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.
<b>Required Medical Information</b>	Chronic HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months
<b>Age Restrictions</b>	3 years of age or older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	Coverage duration will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.

# SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

## Products Affected

- VOSEVI

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	(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.
<b>Required Medical Information</b>	Current HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	Coverage duration will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.

# SOLRIAMFETOL

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## Products Affected

- SUNOSI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, psychiatrist, or specialist in sleep medicine
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	<p><b>EXCESSIVE DAYTIME SLEEPINESS (EDS) WITH NARCOLEPSY: INITIAL:</b> (1) Narcolepsy is confirmed by ONE of the following: a) Multiple Sleep Latency Test (MSLT) showing both a mean sleep latency of 8 minutes or less AND 2 or more early-onset rapid eye movement (REM) sleep test periods (SOREMPs), b) Multiple Sleep Latency Test (MSLT) showing both a mean sleep latency of 8 minutes or less AND one early-onset rapid eye movement (REM) sleep test period (SOREMP) AND additionally one SOREMP (within approximately 15 minutes) on a polysomnography the night preceding the MSLT, with the polysomnography ruling out non-narcolepsy causes of excessive daytime sleepiness (EDS), OR c) Low orexin (aka hypocretin) levels on a cerebrospinal fluid (CSF) assay. (2) Excessive Daytime Sleepiness (EDS) persisting for at least 3 months and Epworth Sleepiness Scale (ESS) score of more than 10. (3) Trial of or contraindication to one amphetamine derivative (e.g., amphetamine sulfate, methylphenidate, etc.) AND modafinil or armodafinil.</p> <p><b>RENEWAL:</b> Demonstrated 25% or more improvement in Epworth Sleepiness Scale (ESS) scores compared to baseline.</p> <p><b>EXCESSIVE DAYTIME SLEEPINESS (EDS) WITH OBSTRUCTIVE SLEEP APNEA (OSA):</b></p> <p><b>INITIAL:</b> (1) OSA confirmed by one of the following: a) polysomnography, b) home sleep apnea testing devices, or c) hospital-based bedside monitoring. (2) Excessive Daytime Sleepiness (EDS) persisting for at least 3 months and Epworth Sleepiness Scale (ESS) score of more than 10. (3) Trial of or contraindication to modafinil or armodafinil. (4) Receiving ongoing treatment to address the obstructive causes of OSA, for at least one month since initiation, and has been counseled on weight-loss intervention (if BMI greater than 30).</p> <p><b>RENEWAL:</b> Demonstrated 25% or more improvement in Epworth Sleepiness Scale (ESS) scores compared to baseline</p>

# SOMATROPIN

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## Products Affected

- NORDITROPIN FLEXPPO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: SEROSTIM, ZORBTIVE: Prescribed for athletic enhancement or anti-aging purposes. GENOTROPIN, HUMATROPE, NORTIDROPIN FLEXPPO, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, ZOMACTON: Prescribed for athletic enhancement, anti-aging purposes, or idiopathic short stature.

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p><b>INITIAL:</b>  <b>HIV WASTING/CACHEXIA:</b>            ONE of the following criteria for weight loss:            10% unintentional weight loss over 12 months            7.5% unintentional weight loss over 6 months            5% body cell mass (BCM) loss within 6 months            BCM less than 35% (men) AND a body mass index (BMI) less than 27 kg per meter squared            BCM less than 23% (women) of total body weight AND a body mass index (BMI) less than 27 kg per meter squared            BMI less than 18.5 kg per meter squared  <b>PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD):</b>            (1) Epiphyses are NOT closed (as confirmed by radiograph of the wrist and hand), and (2) ONE of the following criteria for short stature: a) Height greater than or equal to 2 standard deviations (SD) below the mean height for normal children of the same age and gender, b) Height velocity less than the 25th percentile for age, or c) Documented low peak growth hormone (less than 10ng/mL) on two GH stimulation tests or insulin-like growth factor 1 (IGF-1) greater than or equal to 2 SD below the mean for age and gender.  <b>TURNER SYNDROME, NOONAN SYNDROME, SMALL GESTATIONAL AGE (SGA), SHOX DEFICIENCY:</b>            (1) Epiphyses are NOT closed (as confirmed by radiograph of the wrist and hand), and (2) Height greater than or equal to 2 standard deviations (SD) below the mean height for normal children of the same age and gender.  <b>PRADER-WILLI SYNDROME (PWS):</b>            (1) Confirmed genetic diagnosis of PWS.  <b>GROWTH FAILURE SECONDARY TO CHRONIC KIDNEY DISEASE (CKD):</b> (1) Height or growth velocity greater than or equal to 2 standard deviations (SD) below the mean for normal children of the same age and gender</p>
<b>Age Restrictions</b>	None

PA Criteria	Criteria Details
<b>Prescriber Restrictions</b>	<p>INIT:  HIV WASTING/CACHEXIA: Prescribed by/in consult w/ gastroenterologist, nutritional support specialist, or infectious disease specialist.  SHORT BOWEL SYND: Prescribed by/in consult w/ gastroenterologist.  GROWTH FAILURE 2ND TO CKD: Prescribed by/in consult with nephrologist.  INIT/RNWL:  PEDIATRIC GHD, TURNER SYN, NOONAN SYN, PRADER-WILLI SYN, SMALL GESTATIONAL AGE, SHOX DEFICIENCY, ADULT GHD: Prescribed by/in consultation with endocrinologist</p>
<b>Coverage Duration</b>	<p>INIT/RNWL:  SEROSTIM: 12 wk  ZORBTIVE: max 4 wk/lifetime  Others: 12 mo</p>

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INIT: HIV WASTING/CACHEXIA: (1) on HIV anti-retroviral, (2) inadequate response to prev. tx, (3) inadequate response to prev. pharm. tx incl. one: cyproheptadine, Marinol, or Megace, (4) Alt. causes of wasting ruled out, (5) Hypogonadal patients: a) Tot serum testosterone less than 300ng/dL (10.4 nmol/L), b) Low tot serum testosterone level (lab result), obtained w/ in 90 days, or c) Free serum testosterone level less than 5 pg/mL (0.17 nmol/L)]: Trial of testosterone, AND (6) Req. is for Serostim.</p> <p>SHORT BOWEL SYN: (1) On specialized nutritional support, AND (2) Req. is for Zorbtive.</p> <p>PEDIATRIC GHD: (1) Trial of/CI to Norditropin (unless req for Norditropin). (2) Req. is for Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Saizen, Zomacton</p> <p>TURNER SYN: (1) Trial of/CI to Norditropin (unless req for Norditropin). (2) Req. is for Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Zomacton</p> <p>PRADER-WILLI SYN: (1) Trial of/CI to Norditropin (unless req for Norditropin). (2) Req. is for Genotropin, Norditropin Flexpro, Omnitrope</p> <p>SMALL GESTATIONAL AGE: (1) Trial of/CI to Norditropin (unless req for Norditropin), (2) No catch-up growth by age 2 years (for Genotropin, Omnitrope), by age 2 to 4 (for Humatrope, Norditropin flexpro, Zomacton), and (3) Req. is for Genotropin, Humatrope, Norditropin Flexpro, Omnitrope, Zomacton</p> <p>SHOX DEFICIENCY: Req. is for Humatrope, Zomacton</p> <p>NOONAN SYN: Req. is for Norditropin</p> <p>ADULT GHD: (1) Trial of/CI to Norditropin (unless req for Norditropin), (2) Growth hormone deficiency alone or associated w/ multiple hormone deficiencies (hypopituitarism), as a result of pituitary diseases, hypothalamic disease, surgery, radiation therapy, trauma, or continuation of therapy from childhood onset growth hormone deficiency, and (3) Req. is for Genotropin, Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Saizen, Zomacton</p>



PA Criteria	Criteria Details
	<p>GROWTH FAILURE SECONDARY TO CKD: (1) Has NOT undergone a renal transplantation, and (2) Req. is for Nutropin AQ.</p> <p>RNWL: HIV WASTING/CACHEXIA: (1) Has NOT received greater than 24 wks of therapy within plan year, and (2) Has shown clinical benefit in muscle mass and weight (10+ percent increase in wt or BCM from baseline), (3) Taking HIV anti-retroviral therapy</p> <p>SHORT BOWEL SYN: (1) Has NOT been on med for 4 wks</p> <p>PEDIATRIC GHD: (1) Epiphyses NOT closed. (2) ONE from: a) Annual growth velocity of 2+ cm, OR b) Annual growth velocity of 1+ cm for patients near terminal phase of puberty.</p> <p>TURNER SYN, SMALL GESTATIONAL AGE, SHOX DEFICIENCY, NOONAN SYNDROME: (1) Epiphyses NOT closed. (2) Growth velocity of 2+ cm or patient hasnt reached 50th percent of predicted adult ht.</p> <p>PRADER-WILLI SYN: (1) Improvement in body composition.</p> <p>GROWTH FAILURE SECONDARY TO CKD: (1) Has NOT undergone renal transplant. (2) Growth velocity of 2+ cm or patient has not reached 50th percent of predicted adult ht.</p>

# SORAFENIB

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## Products Affected

- NEXAVAR

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

# SUCRALFATE

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## Products Affected

- *sucralfate oral suspension*

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

# SULCONAZOLE NITRATE

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## Products Affected

- EXELDERM TOPICAL CREAM
- EXELDERM TOPICAL SOLUTION
- *sulconazole topical cream*
- *sulconazole topical solution*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Diagnosis of Tinea pedis (athletes foot) (Topical solution only)
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>EXELDERM 1% EXTERNAL SOLUTION:</b>  Patient has a diagnosis of ONE of the following:</p> <ul style="list-style-type: none"> <li>a. Tinea cruris</li> <li>b. Tinea corporis</li> <li>c. Tinea versicolor; AND</li> </ul> <p>Patient has experienced an inadequate treatment response, intolerance, or contraindication to TWO generic formulary alternatives indicated to treat tinea cruris, tinea corporis, and/or tinea versicolor (e.g. clotrimazole, ketoconazole, miconazole, naftifine).</p> <p><b>EXELDERM 1% EXTERNAL CREAM:</b>  Patient has a diagnosis of ONE of the following:</p> <ul style="list-style-type: none"> <li>a. Tinea cruris</li> <li>b. Tinea corporis</li> <li>c. Tinea pedis</li> <li>d. Tinea versicolor; AND</li> </ul> <p>Patient has experienced an inadequate treatment response, intolerance, or contraindication to TWO generic formulary alternatives indicated to treat tinea cruris, tinea corporis, tinea pedis, and/or tinea versicolor (e.g. clotrimazole, ketoconazole, miconazole, naftifine).</p>

# 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
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<p>Prevention of migraine or cluster headache attacks.</p> <p>Nasal Spray: treatment of cluster headache</p> <p>Ischemic coronary artery disease (CAD) (angina pectoris, history of myocardial infarction, or documented silent ischemia) or coronary artery vasospasm, including Prinzmetals angina.</p> <p>Wolff-Parkinson-White syndrome or arrhythmias associated with other cardiac accessory conduction pathway disorders.</p> <p>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.</p> <p>Peripheral vascular disease.</p> <p>Ischemic bowel disease.</p> <p>Uncontrolled hypertension.</p> <p>Recent use (i.e., within 24 hours) of ergotamine-containing medication, ergot-type medication (such as dihydroergotamine or methysergide), or another 5-hydroxytryptamine<sub>1</sub> (5-HT<sub>1</sub>) agonist.</p> <p>Concurrent administration of a monoamine oxidase (MAO)-A inhibitor or recent (within 2 weeks) use of an MAO-A inhibitor.</p> <p>Hypersensitivity to sumatriptan.</p> <p>Severe hepatic impairment.</p>
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	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

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## Products Affected

- *sunitinib*

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



# TADALAFIL

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## Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications unless otherwise excluded from benefit.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<b>BENIGN PROSTATIC HYPERPLASIA:</b> Trial of TWO preferred formulary agents, including ONE agent from EACH of the following classes: (1) 5-alpha-reductase inhibitors: (e.g., finasteride or dutasteride), and (2) Alpha blockers: (e.g., doxazosin, terazosin, tamsulosin, or alfuzosin)

# TAZAROTENE

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## Products Affected

- TAZORAC TOPICAL GEL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Pregnancy Use on more than 20% body surface area
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	ACNE VULGARIS: Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to topical tretinoin. PLAQUE PSORIASIS: Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to at least TWO (2) topical corticosteroids (e.g., clobetasol, fluocinonide, mometasone, triamcinolone).

# TEDIZOLID

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## Products Affected

- SIVEXTRO ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist
<b>Coverage Duration</b>	1 week
<b>Other Criteria</b>	Patient has had a trial and therapeutic failure to other antibiotics to which the organism is susceptible [documentation required]

# TEMOZOLOMIDE - IV

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## Products Affected

- TEMODAR INTRAVENOUS

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

# TEMOZOLOMIDE-PO

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## Products Affected

- *temozolomide*

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

# TEMSIROLIMUS

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## Products Affected

- *temsirolimus*

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

# TENOFOVIR ALAFENAMIDE

## Products Affected

- VEMLIDY

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p><b>INITIAL:</b></p> <p>A. Patient has diagnosis of Chronic Hepatitis B (HBsAg positive or negative for at least 6 months); AND</p> <p>B. There is documented evidence of active viral replication (HBeAG+ and HBV DNA greater than 100,000 copies/mL); AND</p> <p>C. There is documented evidence of active liver disease as demonstrated by persistent elevation in serum ALT (greater than 2 times normal) or moderate to severe hepatitis on biopsy.</p> <p><b>RENEWAL:</b></p> <p>A. Patient has compensated liver disease (no evidence of ascites, hepatic encephalopathy, variceal bleeding, INR less than 1.5x ULN, total bilirubin less than 2.5x ULN, and albumin greater than 3.0 g/dL), AND</p> <p>B. Patient has been tested for and remains HIV-1 negative.</p>
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a Gastroenterologist, Hepatologist, or Infectious Disease Specialist.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 months.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	INITIAL: A. The patient had a trial and failure of Viread or Baraclude/entecavir; OR B. The patient has documented resistance to Viread and/or entecavir (Baraclude). RENEWAL: A. Patient must have a documented diagnosis of chronic hepatitis b virus (HBV) infection, AND B. Prescriber is attesting that patient is responding positively to therapy.



# TERIFLUNOMIDE

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## Products Affected

- AUBAGIO

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

# TESTOSTERONE

## Products Affected

- *testosterone enanthate* (25 mg/2.5gram), 1.62 % (20.25 mg/1.25 gram)
- *testosterone transdermal gel in metered-dose pump* 20.25 mg/1.25 gram (1.62 %)
- *testosterone transdermal gel in packet* 1 %

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications. Gender dysphoria as supported by the compendia (e.g., DrugDex strength of recommendation Class I, IIa, or IIb)
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	GENDER DYSPHORIA: 16 years of age or older ALL OTHER INDICATIONS: None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INIT/RNWL: MALE HYPOGN, GENDER DYSPH: 12 mo. MALE DELAYD PBRTY, FEM METS. BRST CNCR: Lifetime

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b>  <b>MALE HYPOGONADISM:</b> 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.  <b>ANDROID OR TESTRED REQUEST:</b> Require a trial of or contraindication to TWO lower cost agents.</p> <p><b>DELAYED PUBERTY IN MALES NOT DUE TO A PATHOLOGICAL DISORDER or FEMALE WITH METASTATIC BREAST CANCER:</b> Requests for methyltestosterone (Testred or Android) require a trial of or contraindication to intramuscular testosterone enanthate.</p> <p><b>RENEWAL: MALE HYPOGONADISM:</b> (1) Improved symptoms compared to baseline and tolerance to treatment, AND (2) Documentation of normalized serum testosterone levels and hematocrit concentrations compared to baseline.</p>

# TETRABENAZINE

## Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<p>INITIAL/RENEWAL:</p> <p>Patients who are actively suicidal, or in patients with untreated or inadequately treated depression.</p> <p>Patients with hepatic impairment.</p> <p>Patients taking monoamine oxidase inhibitors (MAOIs) or within a minimum of 14 days of discontinuing therapy with an MAOI.</p> <p>Concomitant therapy with reserpine (at least 20 days should elapse after stopping reserpine before starting tetrabenazine).</p> <p>Concomitant therapy with deutetrabenazine or valbenazine.</p>
<b>Required Medical Information</b>	<p>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).</p>
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a neurologist that treats Huntingtons Disease
<b>Coverage Duration</b>	INITIAL/RENEWAL: 3 months. IL: 12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>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.</p> <p>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.</p>

# TEZACAFTOR/IVACAFTOR

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## Products Affected

- SYMDEKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	6 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cystic fibrosis expert
<b>Coverage Duration</b>	INITIAL: 24 weeks. RENEWAL: Lifetime. IL: Initial: 12 months Renewal: Lifetime
<b>Other Criteria</b>	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

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## Products Affected

- THALOMID

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

# THIOGUANINE

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## Products Affected

- TABLOID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



# TOBRAMYCIN INHALED

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## Products Affected

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

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

# TOCILIZUMAB - IV (NSA)

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## Products Affected

- ACTEMRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	RHEUMATOID ARTHRITIS (RA): 18 years of age or older. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA), CYTOKINE RELEASE SYNDROME (CRS): 2 years of age or older.
<b>Prescriber Restrictions</b>	RA/PJIA: Prescribed by or in consultation with a rheumatologist. SJIA: Prescribed by or in consultation with a rheumatologist, dermatologist, or immunologist
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>RA:</b> (1) 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 (2) Trial of or contraindication to the preferred immunomodulator Humira.</p> <p><b>PJIA:</b> (1) Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine, AND (2) Trial of or contraindication to the preferred immunomodulator Humira.</p> <p><b>SJIA:</b> Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.</p> <p>[NOTE: pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify for trials]</p> <p><b>RENEWAL:</b></p> <p><b>RA/PJIA:</b> Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.</p> <p><b>SJIA:</b> (1) Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy, OR (2) Maintained or improved systemic inflammatory disease (e.g., fevers, pain, rash, arthritis)</p>

# TOCILIZUMAB - SQ

## Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSc-ILD): Other etiologies of interstitial lung disease (ILD) [e.g., heart failure/fluid overload, drug-induced lung toxicity (cyclophosphamide, methotrexate, ACE-inhibitors), recurrent aspiration (such as from GERD), pulmonary vascular disease, pulmonary edema, pneumonia, chronic pulmonary thromboembolism, alveolar hemorrhage or ILD caused by another rheumatic disease, such as mixed connective tissue disease (MCTD)]
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	RHEUMATOID ARTHRITIS (RA), GIANT CELL ARTERITIS (GCA), SSc-ILD: 18 years of age or older POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): 2 years of age or older
<b>Prescriber Restrictions</b>	RA/PJIA: Prescribed by or in consultation with a rheumatologist SSc-ILD: Prescribed by or in consultation with a pulmonologist or rheumatologist SJIA: Prescribed by or in consultation with a rheumatologist, dermatologist, or immunologist
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>RA:</b> (1) 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 (2) Trial of or contraindication to the preferred immunomodulator Humira.</p> <p><b>SSc-ILD:</b> Diagnosis is according to the American College of Rheumatology (ACR) and European League Against Rheumatism (EULAR).</p> <p><b>PJIA:</b> (1) Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine, AND (2) Trial of or contraindication to the preferred immunomodulator Humira.</p> <p><b>SJIA:</b> Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.</p> <p>[NOTE: pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify for trials]</p> <p><b>RENEWAL:</b></p> <p><b>RA/PJIA:</b> Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy</p> <p><b>GCA:</b> Diagnosis of GCA.</p> <p><b>SSc-ILD:</b> Experienced a clinical meaningful improvement or maintenance in annual rate of decline.</p> <p><b>SJIA:</b> (1) Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy, OR (2)</p>
	<p>Maintained or improved systemic inflammatory disease (e.g., fevers, pain, rash, arthritis)</p>

# TOFACITINIB

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## Products Affected

- XELJANZ
- XELJANZ XR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	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
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>RA:</b> 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).</p> <p><b>PsA/pcJIA:</b> 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).</p> <p><b>AS:</b> 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).</p> <p><b>UC:</b> 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.</p> <p>[NOTE: Pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify]</p> <p><b>RENEWAL:</b></p> <p><b>RA/PsA/pcJIA:</b> Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.</p> <p><b>AS:</b> 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.</p> <p><b>UC:</b> Diagnosis of moderate to severe UC.</p>

# TOLCAPONE

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## Products Affected

- *tolcapone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<b>INITIAL/RENEWAL:</b> Patients with liver disease, inpatients who were withdrawn from tolcapone because of evidence of tolcapone-induced hepatocellular injury or who have demonstrated hypersensitivity to the drug or its ingredients. Patients with a history of nontraumatic rhabdomyolysis or hyperpyrexia and confusion possibly related to medication.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL: 3 months. RENEWAL: 12 months. IL: 12 months
<b>Other Criteria</b>	<b>INITIAL:</b> Patient will be taking tolcapone concurrently with levodopa/carbidopa; AND Patient is experiencing symptom fluctuations; AND Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to entacapone.  <b>RENEWAL:</b> Documentation has been provided to confirm that therapy has shown substantial clinical benefits; AND Patient does not exhibit clinical evidence of liver disease or two SGPT/ALT or SGOT/AST values greater than the upper limit of normal.



# TOREMIFENE

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## Products Affected

- *toremifene*

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

# TRAMADOL\_ACETAMINOPHEN HYDROCHLORIDE

## Products Affected

- *tramadol-acetaminophen*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	<p>Previous hypersensitivity to tramadol, acetaminophen, or other opioids.</p> <p>Post-operative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy.</p> <p>Significant respiratory depression.</p> <p>Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment.</p> <p>Patients with known or suspected gastrointestinal obstruction, including paralytic ileus.</p> <p>Concurrent use of monoamine oxidase inhibitors (MAOIs) or use within the last 14 days.</p>
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	30 days.
<b>Other Criteria</b>	<p>Patient has a diagnosis of acute pain; AND Patient has had a trial and therapeutic failure with at least TWO oral NSAIDs including, but limited to ibuprofen, naproxen, meloxicam, and nabumetone; AND Patient has had a trial and therapeutic failure with oral tramadol HCl.</p>

# TRAMETINIB DIMETHYL SULFOXIDE

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## Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

# TREPROSTINIL

## Products Affected

- ORENITRAM

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	ORENITRAM: Severe hepatic impairment
<b>Required Medical Information</b>	<p><b>INITIAL:</b>  <b>PULMONARY ARTERIAL HYPERTENSION (PAH) (WHO GROUP 1):</b>            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)</p> <p><b>TYVASO ONLY:</b>  <b>PULMONARY HYPERTENSION (PH) (WHO Group 3):</b>            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</p>
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or given in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	INIT: REMODULIN/ORENITRAM, TYVASO PAH: 12 mo. TYVASO PH G3: INIT: 6 mo. RNWL: All: 12 mo. IL: 12 mo

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p><b>INITIAL:</b></p> <p><b>REMODULIN</b>  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)</p> <p><b>TYVASO</b>  <b>PAH WHO GROUP 1:</b> (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)</p> <p><b>ORENITRAM</b>  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 contraindication to TWO of the following agents from different drug classes: (a) oral endothelin receptor antagonist (e.g.,</p>

PA Criteria	Criteria Details
	<p>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</p> <p>(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</p> <p><b>RENEWAL:</b>  <b>REMODULIN / ORENITRAM:</b>  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</p> <p><b>TYVASO:</b>  <b>PAH WHO GROUP 1:</b> 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</p> <p><b>PH WHO GROUP 3:</b>  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</p>

# TRETINOIN ORAL

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## Products Affected

- *tretinoin (antineoplastic)*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients with known hypersensitivity to tretinoin or other retinoids.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an oncologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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

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## Products Affected

- *triamcinolone acetonide topical aerosol*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to at least <b>THREE</b> 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

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## Products Affected

- *trifluridine*

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

# TRIPTORELIN

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## Products Affected

- TRELSTAR INTRAMUSCULAR  
SUSPENSION FOR  
RECONSTITUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Known hypersensitivity to other GnRH agonists or GnRH.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has a diagnosis of advanced prostate cancer; AND Patient will be using Trelstar as palliative therapy.

# UBROGEPANT

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## Products Affected

- UBRELVY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL: 6 months. RENEWAL: 12 months.
<b>Other Criteria</b>	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

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## Products Affected

- RINVOQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	RA/PSA/UC: 18 years of age or older AD: 12 years of age or older
<b>Prescriber Restrictions</b>	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
<b>Coverage Duration</b>	INITIAL: RA/PSA: 6 months. AD: 4 months. UC: 12 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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.</p> <p>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.</p> <p>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).</p> <p>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).</p> <p>RENEWAL:</p> <p>RA/PSA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.</p> <p>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.</p>

# USTEKINUMAB

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## Products Affected

- STELARA SUBCUTANEOUS

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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.</p> <p>PsA: Trial of or contraindication to one DMARD (disease-modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.</p> <p>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.</p> <p>RENEWAL: PsA WITHOUT PsO: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy.</p> <p>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.</p>

# VALGANCICLOVIR

## Products Affected

- *valganciclovir*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Hypersensitivity to valganciclovir or ganciclovir.
<b>Required Medical Information</b>	PREVENTION OF CMV DISEASE Donor CMV seropositive/Recipient CMV seronegative [D+/R-]
<b>Age Restrictions</b>	Pediatric kidney transplant: 4 months of age and older Pediatric heart transplant: 1 month of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>CYTOMEGALOVIRUS (CMV) RETINITIS: Patient has a documented diagnosis of Cytomegalovirus (CMV) Retinitis; AND Patients has a documented diagnosis of acquired immunodeficiency syndrome (AIDS).</p> <p>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.</p> <p>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.</p>



# VANDETANIB

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## Products Affected

- CAPRELSA ORAL TABLET 100 MG,  
300 MG

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

# VEMURAFENIB

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## Products Affected

- ZELBORAF

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

# VIGABATRIN

## Products Affected

- *vigabatrin oral powder in packet*
- *vigadrone*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Use as a first line agent for complex partial seizures
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	Refractory Complex Partial Seizures: 2 years of age or older Infantile spasms: 1 month to less than 2 years of age
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 3 months. IL: 12 months
<b>Other Criteria</b>	<p><b>INITIAL:</b>  <b>REFRACTORY COMPLEX PARTIAL SEIZURES:</b>            Patient has diagnosis of Refractory Complex Partial Seizures; AND Patients vision has been tested at baseline before beginning treatment and will be tested every 3 months thereafter; AND Patient has had a trial and failure, intolerance, or contraindication to at least TWO formulary anticonvulsants.</p> <p><b>INFANTILE SPASMS:</b>            Patient has diagnosis of Infantile Spasms; AND Prescriber provides confirmation that potential benefit outweighs the potential risk of vision loss; AND Patient's vision is tested, when possible, at baseline before beginning treatment and will be tested every 3 months thereafter.</p> <p><b>RENEWAL: ALL INDICATIONS</b>            (1) Clinical benefit has been demonstrated (2) Confirmation of vision test within the last 3 months</p>

# VILAZODONE

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## Products Affected

- VIIBRYD ORAL TABLET
- VIIBRYD ORAL TABLETS,DOSE  
PACK 10 MG (7)- 20 MG (23)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Patients taking, or within 14 days of stopping, monoamine oxidase inhibitors (MAOIs), including MAOIs such as linezolid or intravenous methylene blue.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	MAJOR DEPRESSIVE DISORDER Patient has had an adequate trial and failure, intolerance, or contraindication with at least ONE (1) generic SSRI; AND Patient has had had an adequate trial and failure, intolerance, or contraindication with at least ONE (1) generic SNRI. [Documentation Required]

# VORICONAZOLE

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## Products Affected

- *voriconazole oral*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Coadministration of cisapride, pimozone, 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).
<b>Required Medical Information</b>	Fungal culture and other relevant laboratory studies (including histopathology) need to be obtained to isolate and identify causative organisms
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<b>TREATMENT OF INVASIVE ASPERGILLUS</b> 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.  <b>ALL OTHER INDICATIONS:</b> Patient has trial and failure, contraindication, or intolerance to fluconazole.

# VORINOSTAT

## Products Affected

- ZOLINZA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: Patient has disease progression while taking Zolinza (vorinostat) or another histone deacetylase inhibitor (i.e., romidepsin).
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	INITIAL: 3 months. RENEWAL: 12 months. IL: 12 months
<b>Other Criteria</b>	INITIAL: Patient has a documented diagnosis of Cutaneous T-cell Lymphoma (CTCL) with cutaneous manifestations; AND Patient has progressive, persistent, or recurrent disease on or following two systemic therapies.  RENEWAL: 1) Patient must have a clinical response to treatment within 3 to 6 months of beginning treatment, 2) Positive clinical response is defined as: Objective measures for disease activity and may include pruritis or decrease plaques or erythema. Zolinza will not be reapproved if no response after 6 months of treatment.

# VORTIOXETINE

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## Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Use of MAOIs intended to treat psychiatric disorders with Trintellix or within 21 days of stopping treatment with Trintellix. Concurrent use with linezolid or IV methylene blue.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p><b>MAJOR DEPRESSIVE DISORDER</b></p> <p>The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patients medical records; AND Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to ALL of the following: (i) At least one generic SSRI (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine HCl immediate-release, sertraline) (ii) At least one SNRI (duloxetine, venlafaxine, desvenlafaxine, Fetzima) (iii) Viibryd.</p>

# ZILEUTON

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## Products Affected

- *zileuton*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications.
<b>Exclusion Criteria</b>	Use in the reversal of bronchospasm in acute asthma attacks. Patients with active liver disease or persistent hepatic function enzyme elevations greater than or equal to 3 times the upper limit of normal (greater than or equal to 3xULN). Patients with a history of allergic reaction to zileuton.
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient has diagnosis of Asthma; Patient has had a trial and therapeutic failure, intolerance, or contraindication to ALL of the following: montelukast and zafirlukast (medication usage must be supported by documentation from the patients chart notes/medical records).





## INDEX

ABILIFY MAINTENA.....	23	AUBAGIO.....	328
<i>abiraterone oral tablet 250 mg, 500 mg</i> .....	2	AVONEX INTRAMUSCULAR PEN INJECTOR KIT.....	171
ABSORICA ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG.....	173	AVONEX INTRAMUSCULAR SYRINGE KIT.....	171
<i>accutane</i> .....	173	AZASAN.....	29
<i>acitretin</i> .....	5	AZASITE.....	31
ACTEMRA.....	337, 339	<i>azelastine-fluticasone</i> .....	30
ACTEMRA ACTPEN.....	339	BAXDELA INTRAVENOUS.....	84
ACTIMMUNE.....	170	BAXDELA ORAL.....	84
<i>acyclovir topical ointment</i> .....	6	<i>benzhydrocodone-acetaminophen</i> .....	4
<i>adefovir</i> .....	10	<i>bepotastine besilate</i> .....	34
ADEMPAS.....	288	BESIVANCE.....	35
AIMOVIG AUTOINJECTOR.....	112	<i>betaine</i> .....	36
AKYNZEO (NETUPITANT).....	217	BETASERON.....	171
<i>albendazole</i> .....	12	BETOPTIC S.....	37
ALIMTA.....	254	<i>bexarotene</i> .....	38
ALINIA ORAL SUSPENSION FOR RECONSTITUTION.....	220	<i>bosentan</i> .....	107
ALOCRI.....	216	BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG.....	39
ALOMIDE.....	191	BRIVIACT.....	42
<i>alosetron</i> .....	15	BUPRENEX.....	43
ALTABAX.....	280	<i>buprenorphine</i> .....	43
<i>alyq</i> .....	249	<i>buprenorphine hcl injection</i> .....	43
<i>ambrisentan</i> .....	107	<i>busulfan</i> .....	45
<i>aminocaproic acid oral tablet</i> .....	17	<i>calcitonin (salmon) injection</i> .....	46
<i>amnestem</i> .....	173	<i>calcitriol topical</i> .....	47
APADAZ.....	4	<i>capecitabine oral tablet 150 mg, 500 mg</i> ....	50
APIDRA SOLOSTAR U-100 INSULIN.....	167	CAPRELSA ORAL TABLET 100 MG, 300 MG.....	360
APIDRA U-100 INSULIN.....	167	<i>cevimeline</i> .....	57
APOKYN.....	20	<i>chlorzoxazone oral tablet 500 mg</i> .....	59
APTIOM.....	115	CHORIONIC GONADOTROPIN, HUMAN INTRAMUSCULAR.....	60
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML..	78	CIMZIA.....	53
ARANESP (IN POLYSORBATE) INJECTION SYRINGE.....	78	CIMZIA POWDER FOR RECONST... 53	
ARCALYST.....	285	CIMZIA STARTER KIT.....	53
<i>aripiprazole oral solution</i> .....	23	<i>cinacalcet</i> .....	61
<i>armodafinil</i> .....	25	CIPRO HC.....	63
<i>asenapine maleate</i> .....	26	<i>claravis</i> .....	173
<i>atovaquone</i> .....	27	<i>clobazam</i> .....	64
		<i>clonidine hcl oral tablet extended release 12 hr</i> .....	65

CORLANOR ORAL TABLET .....	176	<i>erlotinib oral tablet 100 mg, 150 mg, 25</i>	
CORTISPORIN-TC .....	66	<i>mg</i> .....	114
COSENTYX .....	295	ERTACZO .....	299
COSENTYX (2 SYRINGES) .....	295	ESBRIET ORAL CAPSULE .....	262
COSENTYX PEN .....	295	ESBRIET ORAL TABLET 801 MG .....	262
COSENTYX PEN (2 PENS) .....	295	<i>ethacrynic acid</i> .....	119
CRESEMBA ORAL .....	172	<i>everolimus (antineoplastic) oral tablet 2.5</i>	
CRINONE .....	272, 273	<i>mg, 5 mg, 7.5 mg</i> .....	120
CYSTADANE .....	36	<i>everolimus (immunosuppressive) oral</i>	
CYSTAGON .....	69	<i>tablet 0.25 mg, 0.5 mg, 0.75 mg</i> .....	121
<i>dacarbazine</i> .....	71	EXELDERM TOPICAL CREAM .....	315
<i>dalfampridine</i> .....	72	EXELDERM TOPICAL SOLUTION .....	315
<i>danazol</i> .....	76	EXTAVIA .....	171
<i>deferasirox oral tablet, dispersible</i> .....	81	FACTIVE .....	141
<i>deferiprone oral tablet 500 mg</i> .....	83	FARYDAK .....	237
<i>desmopressin injection</i> .....	89	<i>fentanyl transdermal patch 72 hour 100</i>	
DIFICID .....	123	<i>mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr,</i>	
<i>dihydroergotamine nasal</i> .....	92	<i>75 mcg/hr</i> .....	122
<i>dimethyl fumarate</i> .....	94	FERRIPROX ORAL SOLUTION .....	83
DIPENTUM .....	223	FERRIPROX ORAL TABLET 500	
<i>docetaxel intravenous solution 160 mg/16</i>		MG .....	83
<i>ml (10 mg/ml), 160 mg/8 ml (20 mg/ml),</i>		FETZIMA .....	188
<i>20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml),</i>		<i>flucytosine</i> .....	126
<i>80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10</i>		<i>flurandrenolide topical cream</i> .....	127
<i>mg/ml)</i> .....	95	<i>flurandrenolide topical lotion</i> .....	127
<i>doxepin topical</i> .....	98	<i>fondaparinux</i> .....	130
<i>doxercalciferol oral</i> .....	99	<i>formoterol fumarate</i> .....	132
DUPIXENT PEN .....	100	FOSAMAX PLUS D .....	14
DUPIXENT SYRINGE .....	100	FRAGMIN SUBCUTANEOUS	
DYSPORT .....	3	SYRINGE .....	74
ELIGARD .....	151	<i>fulvestrant</i> .....	133
ELIGARD (3 MONTH) .....	151	FYCOMPA ORAL TABLET .....	258
ELIGARD (4 MONTH) .....	151	<i>fyremadel</i> .....	138
ELIGARD (6 MONTH) .....	151	<i>ganirelix</i> .....	138
ELMIRON .....	257	<i>gemcitabine</i> .....	139
EMCYT .....	116	GILENYA ORAL CAPSULE 0.5 MG .....	125
EMGALITY PEN .....	135	GILOTRIF .....	11
EMGALITY SYRINGE .....	135	<i>glatiramer</i> .....	142
ENBREL .....	117	<i>glatopa</i> .....	142
ENBREL MINI .....	117	GLEOSTINE .....	192
ENBREL SURECLICK .....	117	GONAL-F RFF REDI-JECT .....	129
EPCLUSA .....	304	HARVONI .....	183
EPIDIOLEX .....	49	HUMIRA PEN .....	7
<i>ergoloid</i> .....	113	HUMIRA PEN CROHNS-UC-HS	
		START .....	7

HUMIRA PEN PSOR-UVEITS-ADOL HS.....	7	<i>lanthanum</i> .....	260
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML.....	7	<i>lapatinib</i> .....	181
HUMIRA(CF).....	7	LASTACAFT.....	13
HUMIRA(CF) PEDI CROHNS STARTER.....	7	LATUDA.....	195
HUMIRA(CF) PEN.....	7	<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i> .....	184
HUMIRA(CF) PEN CROHNS-UC-HS... ..	7	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).....	185
HUMIRA(CF) PEN PEDIATRIC UC....	7	LEUKERAN.....	58
HUMIRA(CF) PEN PSOR-UV-ADOL HS.....	7	LEUKINE INJECTION RECON SOLN.....	294
<i>hydrocodone bitartrate oral capsule, oral only, er 12hr</i> .....	159	<i>leuprolide subcutaneous kit</i> .....	151
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg.</i>	160	<i>levofloxacin ophthalmic (eye) drops 0.5 %</i> .....	187
HYQVIA.....	166	<i>lidocaine topical adhesive patch,medicated 5 %</i> .....	189
IBRANCE.....	231	<i>luliconazole</i> .....	193
<i>icatibant</i> .....	157	LUPANETA PACK (1 MONTH).....	186
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG.....	266	LUPRON DEPOT.....	154
IDHIFA.....	106	LUPRON DEPOT (3 MONTH).....	154
<i>imatinib oral tablet 100 mg, 400 mg</i> .....	165	LUPRON DEPOT (4 MONTH).....	154
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG.....	161	LUPRON DEPOT (6 MONTH).....	154
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG.....	161	LUPRON DEPOT-PED	
IMPAVIDO.....	206	INTRAMUSCULAR KIT 11.25 MG... ..	154
INCRELEX.....	196	LYNPARZA ORAL TABLET 100 MG, 150 MG.....	222
INLYTA.....	28	LYSODREN.....	208
INTRAROSA.....	269	MATULANE.....	271
INTRON A INJECTION RECON SOLN.....	168	MAVYRET ORAL TABLET.....	143
INVEGA SUSTENNA.....	232	MEKINIST ORAL TABLET 0.5 MG, 2 MG.....	346
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i> .....	173	<i>melphalan</i> .....	197
<i>itraconazole</i> .....	174	<i>melphalan hcl</i> .....	197
JAKAFI.....	293	<i>memantine oral solution</i> .....	198
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3).....	281	MENOPUR.....	199
KRISTALOSE.....	179	<i>mesalamine rectal suppository</i> .....	200
<i>lactulose oral packet</i> .....	179	MESNEX ORAL.....	201
<i>lanreotide</i> .....	180	<i>metaxalone</i> .....	202
		<i>methoxsalen</i> .....	203

MIRVASO TOPICAL GEL WITH PUMP.....	41	PHOSLYRA.....	48
<i>modafinil</i> .....	209	<i>pimecrolimus</i> .....	261
MOTOFEN.....	91	PLEGRIDY SUBCUTANEOUS.....	171
MOVANTIK.....	212	POMALYST.....	265
<i>myorisan</i> .....	173	<i>posaconazole oral tablet, delayed release (drlec)</i> .....	267
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR.....	207	PRALUENT PEN.....	244
NATACYN.....	215	PRED-G.....	270
NAYZILAM.....	204	PRED-G S.O.P.....	270
NEUPRO.....	292	PREGNYL.....	60
NEXAVAR.....	313	PROLIA.....	86
<i>nilutamide</i> .....	219	PROMACTA ORAL TABLET.....	105
<i>nitazoxanide</i> .....	220	PULMOZYME.....	97
NIVESTYM.....	124	<i>pyrazinamide</i> .....	275
NORDITROPIN FLEXPRO.....	308	<i>pyridostigmine bromide oral syrup</i> .....	276
NOVAREL INTRAMUSCULAR RECON SOLN 10,000 UNIT.....	60	<i>pyrimethamine</i> .....	277
NURTEC ODT.....	286	<i>ranolazine</i> .....	279
NYVEPRIA.....	250	REGRANEX.....	32
<i>octreotide acetate</i> .....	221	REPATHA PUSHTRONEX.....	244
OPSUMIT.....	107	REPATHA SURECLICK.....	244
ORENITRAM.....	347	REPATHA SYRINGE.....	244
ORKAMBI ORAL TABLET.....	194	RETACRIT.....	109
OSPHENA.....	226	REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG.....	184
OTEZLA.....	21	REXULTI.....	40
OTEZLA STARTER.....	21	REYVOW.....	182
<i>oxandrolone</i> .....	18	<i>rifabutin</i> .....	282
<i>oxiconazole</i> .....	228	RINVOQ.....	355
<i>oxycodone oral tablet, oral only, ext. rel. 12 hr 10 mg, 20 mg, 40 mg</i> .....	229	<i>sajazir</i> .....	157
OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG.....	229	SANDIMMUNE ORAL SOLUTION... ..	68
<i>oxymorphone oral tablet extended release 12 hr</i> .....	230	SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON.....	221
<i>paliperidone</i> .....	233	SAVELLA.....	205
<i>paricalcitol oral</i> .....	238	<i>sevelamer carbonate oral powder in packet</i> .....	260
<i>paroxetine hcl oral suspension</i> .....	240	<i>sevelamer hcl</i> .....	260
PEGASYS SUBCUTANEOUS SYRINGE.....	251	SIGNIFOR.....	241
<i>penicillamine oral tablet</i> .....	255	SIGNIFOR LAR.....	242
PHENEX-1.....	263	<i>sildenafil (pulm. hypertension) oral tablet</i> .....	249
PHENEX-2.....	263	<i>silodosin</i> .....	300
<i>phenoxybenzamine</i> .....	259	SIMPONI.....	148
		SIMPONI ARIA.....	145
		<i>sirolimus</i> .....	301

SIRTURO ORAL TABLET 100 MG.....	33	<i>tolcapone</i> .....	343
SIVEXTRO ORAL.....	322	<i>toremifene</i> .....	344
SKYRIZI.....	290	<i>tramadol-acetaminophen</i> .....	345
SOMATULINE DEPOT.....	180	TRELSTAR INTRAMUSCULAR	
SOMAVERT.....	253	SUSPENSION FOR	
SOVALDI ORAL TABLET.....	302	RECONSTITUTION.....	353
SPRYCEL.....	80	TREMFYA.....	156
STELARA SUBCUTANEOUS.....	357	<i>tretinoin (antineoplastic)</i> .....	350
<i>sucralfate oral suspension</i> .....	314	<i>triamcinolone acetonide topical aerosol</i> ...	351
<i>sulconazole topical cream</i> .....	315	<i>trifluridine</i> .....	352
<i>sulconazole topical solution</i> .....	315	TRINTELLIX.....	366
<i>sumatriptan nasal spray, non-aerosol 20</i>		TRULANCE.....	264
<i>mg/lactuation, 5 mg/lactuation</i> .....	317	UBRELVY.....	354
<i>sumatriptan succinate subcutaneous pen</i>		UPTRAVI ORAL.....	297
<i>injector 6 mg/0.5 ml</i> .....	317	<i>valganciclovir</i> .....	359
<i>sumatriptan succinate subcutaneous</i>		VARUBI ORAL.....	291
<i>solution</i> .....	317	VELPHORO.....	260
<i>sunitinib</i> .....	319	VEMLIDY.....	326
SUNOSI.....	306	VENTAVIS.....	163
SYMDEKO.....	333	VERZENIO.....	1
SYMLINPEN 120.....	268	<i>vigabatrin oral powder in packet</i> .....	362
SYMLINPEN 60.....	268	<i>vigadrone</i> .....	362
SYMPROIC.....	211	VIIBRYD ORAL TABLET.....	363
SYNAGIS.....	234	VIIBRYD ORAL TABLETS, DOSE	
SYNAREL.....	152	PACK 10 MG (7)- 20 MG (23).....	363
TABLOID.....	335	VIMPAT ORAL SOLUTION.....	178
<i>tadalafil (pulm. hypertension)</i> .....	249	VIMPAT ORAL TABLET.....	178
<i>tadalafil oral tablet 2.5 mg, 5 mg</i> .....	320	VIVITROL.....	213
TAFINLAR.....	70	<i>voriconazole oral</i> .....	364
TAKHZYRO.....	157	VOSEVI.....	305
TASIGNA.....	218	VOTRIENT.....	243
TAZORAC TOPICAL GEL.....	321	VRAYLAR.....	51
TEMODAR INTRAVENOUS.....	323	XALKORI.....	67
<i>temozolomide</i> .....	324	XELJANZ.....	341
<i>temsirolimus</i> .....	325	XELJANZ XR.....	341
<i>testosterone enanthate</i> .....	329	XERAVA.....	111
<i>testosterone transdermal gel in metered-</i>		XIFAXAN ORAL TABLET 200 MG,	
<i>dose pump 20.25 mg/1.25 gram (1.62%)</i>	329	550 MG.....	283
<i>testosterone transdermal gel in packet 1%</i>		XOLAIR.....	224
<i>(25 mg/2.5 gram), 1.62% (20.25 mg/1.25</i>		XPOVIO ORAL TABLET 60MG	
<i>gram), 1.62% (40.5 mg/2.5 gram)</i> .....	329	TWICE WEEK (120 MG/WEEK).....	298
<i>tetrabenazine</i> .....	331	XTANDI.....	108
THALOMID.....	334	ZELBORAF.....	361
<i>tobramycin in 0.225% nacl</i> .....	336	<i>zenatane</i> .....	173
<i>tobramycin with nebulizer</i> .....	336	ZEPATIER.....	103

ZERVIAE .....	56
ZIEXTENZO .....	250
<i>zileuton</i> .....	367
ZIRGAN .....	137
ZOLINZA .....	365
ZYDELIG .....	162
ZYKADIA ORAL TABLET .....	52