Prior Authorization Detail
May 2022

GENERAL DISCLAIMER:

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

ABEMACICLIB

Products Affected

- VERZENIO

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

ABIRATERONE

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*

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

ABOBOTULINUMTOXINA

Products Affected

- DYSPORT

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

ACETAMINOPHEN-BENZHYDROCODONE

Products Affected

- APADAZ
- *benzhydrocodone-acetaminophen*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	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.
Required Medical Information	None
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, a pain management specialist
Coverage Duration	3 months
Other Criteria	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

Products Affected

- *acitretin*

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

ACYCLOVIR OINTMENT

Products Affected

- *acyclovir topical ointment*

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

ADALIMUMAB

Products Affected

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

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

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

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

ADEFOVIR

Products Affected

- *adefovir*

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

AFATINIB

Products Affected

- GILOTRIF

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

ALBENDAZOLE

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 (Taenia solium) (2) Cystic hadatid disease of the liver, lung, and peritoneum caused by larval form of the dog tapeworm (Echinococcus granulosus).

AMINOCAPROIC ACID

Products Affected

- *aminocaproic acid oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	Patients with active intravascular clotting process or disseminated intravascular coagulation (DIC) without concomitant heparin.
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	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
Covered Uses	All FDA approved indications. Anadrol-50: Fanconis anemia, cachexia associated with AIDS. Oxandrin: Cachexia associated with AIDS, Turners syndrome
Exclusion Criteria	INITIAL: Contraindication to anabolic steroid therapy: a) Known or suspected carcinoma of the prostate or breast in male patients b) Known or suspected carcinoma of the breast in females with hypercalcemia c) Known or suspected nephrosis (the nephrotic phase of nephritis) d) Known or suspected hypercalcemia e) Severe hepatic dysfunction
Required Medical Information	INITIAL: CACHEXIA ASSOCIATED WITH AIDS: 1) Patient has a documented viral load (with date) of less than 200 copies per mL within the past 3 months. 2) Patient meets one of the following: a) 10% unintentional weight loss over 12 months b) 7.5% unintentional weight loss over 6 months c) 5% body cell mass (BCM) loss within 6 months d) Body cell mass (BCM) of less than 35% (men) and a body mass index (BMI) of less than 27 kg per meter squared e) Body cell mass (BCM) of less than 23% (women) of total body weight and a body mass index (BMI) of less than 27 kg per meter squared f) BMI of less than 18.5 kg per meter squared. RENEWAL: 1) Patient has a documented viral load (with date) of less than 200 copies per mL within the past 3 months 2) Patient has responded to therapy as measured by at least a 10% increase in weight from baseline (current weight must have been measured within the last 4 weeks, document date of measurement)
Age Restrictions	None

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

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER

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

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

ARIPIPRAZOLE

Products Affected

- ABILIFY MAINTENA
- *aripiprazole oral solution*

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

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

ARMODAFINIL

Products Affected

- *armodafinil*

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

ASENAPINE

Products Affected

- *asenapine maleate*

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

ATOVAQUONE

Products Affected

- *atovaquone*

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

AXITINIB

Products Affected

- INLYTA

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

AZATHIOPRINE

Products Affected

- AZASAN

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

AZITHROMYCIN

Products Affected

- AZASITE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	None
Required Medical Information	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
Age Restrictions	1 year of age and older
Prescriber Restrictions	None
Coverage Duration	7 days
Other Criteria	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

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	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.
Required Medical Information	None
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	5 months
Other Criteria	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
Covered Uses	All FDA approved indications and pulmonary extensively drug resistant tuberculosis (XDR-TB)
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	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
Prescriber Restrictions	None
Coverage Duration	PULM MDR-TB, CMBO W/ 3 ANTIBX: 24 wk PULM MDR-TB, XDR-TB, CMBO W/ PRETOMANID AND LINEZOLID: 26 wk
Other Criteria	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

BESIFLOXACIN

Products Affected

- BESIVANCE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	1 year of age and older
Prescriber Restrictions	Prescribed by or in conjunction with an optometrist or ophthalmologist
Coverage Duration	7 days
Other Criteria	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

Products Affected

- *betaine*
- CYSTADANE

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

BETAXOLOL

Products Affected

- BETOPTIC S

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with sinus bradycardia, greater than a first degree atrioventricular block, cardiogenic shock, or patients with overt cardiac failure.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of chronic 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

Products Affected

- *bexarotene*

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

BOSUTINIB

Products Affected

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

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

BREXPIPRAZOLE

Products Affected

- REXULTI

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

BUPRENORPHINE PAIN

Products Affected

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

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

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

BUSULFAN

Products Affected

- *busulfan*

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

CALCITONIN SALMON

Products Affected

- *calcitonin (salmon) injection*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	Hypersensitivity of calcitonin-salmon or any component of the product Asymptomatic Pagets disease.
Required Medical Information	Pagets Disease of Bone: Patient has moderate to severe disease characterized by polyostotic involvement with elevated serum alkaline phosphatase and urinary hydroxyproline excretion 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).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Hypercalcemia: 1 month, All others: 12 months. IL: 12 months
Other Criteria	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. Hypercalcemia: Patient has a documented diagnosis of hypercalcemia 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.

CALCIUM ACETATE

Products Affected

- PHOSLYRA

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

CAPECITABINE

Products Affected

- *capecitabine oral tablet 150 mg, 500 mg*

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

CERITINIB

Products Affected

- ZYKADIA ORAL TABLET

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

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST
- CIMZIA STARTER KIT

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

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

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

CEVIMELINE

Products Affected

- *cevimeline*

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

chlorambucil

Products Affected

- LEUKERAN

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

CHLORZOXAZONE

Products Affected

- *chlorzoxazone oral tablet 500 mg*

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

CINACALCET

Products Affected

- *cinacalcet*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	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.
Required Medical Information	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 mg2/DL2. 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.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	INITIAL: 3 mo, FIRST RENEWAL: 6 mo, ADD RENEWALS: 12 mo. IL: 12 mo

PA Criteria	Criteria Details
Other Criteria	INITIAL: SECONDARY HYPERPARATHYROIDISM 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). INITIAL: PARATHYROID CARCINOMA Patient has a documented diagnosis of hypercalcemia due to parathyroid carcinoma. INITIAL: PRIMARY HYPERPARATHYROIDISM Patient has s documented diagnosis of severe hypercalcemia due to primary hyperparathyroidism; AND Patient is unable to undergo parathyroidectomy.

CIPROFLOXACIN/HYDROCORTISONE

Products Affected

- CIPRO HC

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	1 year of age and older
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	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

Products Affected

- *clobazam*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist
Coverage Duration	12 months
Other Criteria	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).

Colistin/Hydrocortisone/Neomycin/Thonzonium

Products Affected

- CORTISPORIN-TC

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	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)
Required Medical Information	None
Age Restrictions	1 year of age and older
Prescriber Restrictions	None
Coverage Duration	10 days
Other Criteria	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

Products Affected

- XALKORI

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

CYCLOSPORINE SOLUTION

Products Affected

- SANDIMMUNE ORAL SOLUTION

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

CYSTEAMINE

Products Affected

- CYSTAGON

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

DABRAFENIB

Products Affected

- TAFINLAR

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

DACARBAZINE

Products Affected

- *dacarbazine*

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

DALFAMPRIDINE

Products Affected

- *dalfampridine*

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

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

DANAZOL

Products Affected

- *danazol*

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

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

DASATINIB

Products Affected

- SPRYCEL

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

DEFERASIROX

Products Affected

- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: 2 lab values in the previous 3 months showing the patients serum ferritin levels are consistently greater than 1000mcg/L. CHRONIC IRON OVERLOAD RESULTING FROM NTDT: 2 lab values in the previous 3 months showing the patients serum ferritin levels are consistently greater than 300mcg/L RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: 2 lab values in the previous 3 months showing the patients serum ferritin levels are consistently greater than 500mcg/L. CHRONIC IRON OVERLOAD RESULTING FROM NTDT: 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.
Age Restrictions	CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: 2 years of age or older. CHRONIC IRON OVERLOAD RESULTING FROM NTDT: 10 years of age or older
Prescriber Restrictions	Prescribed by or given in consultation with a hematologist or hematologist-oncologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

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

DENOSUMAB

Products Affected

- PROLIA

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

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

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

DESMOPRESSIN SOLUTION

Products Affected

- *desmopressin injection*

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

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

DIFENOXIN/ATROPINE

Products Affected

- MOTOFEN

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

DIHYDROERGOTAMINE MESYLATE NASAL

Products Affected

- *dihydroergotamine nasal*

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

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

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate*

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	Brand Tecfidera requires trial of generic dimethyl fumarate

DOCETAXEL

Products Affected

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

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

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

DORNASE ALFA

Products Affected

- PULMOZYME

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

DOXEPIN CREAM

Products Affected

- *doxepin topical*

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

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

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

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

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

ELTROMBOPAG

Products Affected

- PROMACTA ORAL TABLET

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

ENASIDENIB

Products Affected

- IDHIFA

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

ENDOTHELIN RECEPTOR ANTAGONISTS

Products Affected

- *ambrisentan*
- *bosentan*
- OPSUMIT

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

ENZALUTAMIDE

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	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) RENEWAL: Diagnosis of CRPC (non-metastatic and metastatic) or MCSPC.

EPOETIN ALFA-EPBX

Products Affected

- RETACRIT

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

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

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

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

ERGOLOID MESYLATES ORAL

Products Affected

- *ergoloid*

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

ERLOTINIB

Products Affected

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

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

ESLICARBAZEPINE

Products Affected

- APTIOM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypersensitivity to eslicarbazepine acetate or oxcarbazepine
Required Medical Information	None
Age Restrictions	4 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist
Coverage Duration	12 months
Other Criteria	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.)

ESOMEPRAZOLE MAGNESIUM/NAPROXEN

Products Affected

- *naproxen-esomeprazole*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypersensitivity to naproxen, esomeprazole magnesium, omeprazole, substituted benzimidazoles. History of asthma, urticaria, or allergic-type reactions to aspirin or other NSAIDs. CABG surgery. Concomitant use of rilpivirine-containing products.
Required Medical Information	None
Age Restrictions	JIA: 12 years of age and older All other indications: 18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	The patient has a diagnosis of osteoarthritis, juvenile idiopathic arthritis, rheumatoid arthritis and/or ankylosing spondylitis; AND The patient has a history or current diagnosis of peptic ulcer (gastric or duodenal), gastrointestinal (GI) bleed, GI obstruction, or GI perforation; AND The Patient has had a tried and therapeutic failure, intolerance or contraindication to a 28-day trial of all of the following, each in combination with prescription strength naproxen (medication usage must be supported by documentation from the patients chart notes/medical records): (i) omeprazole product (OTC or RX) (ii) lansoprazole (OTC or RX) (iii) pantoprazole (iv) Nexium 20mg OTC 24 HR (v) Dexilant (Prior Authorization) (4) Tried and failed, intolerance or contraindication to Mobic (meloxicam), Voltaren (diclofenac) and Relafen (nabumetone) (supported by documentation from the patients chart notes/medical records/electronic claim history) (5) Tried and failed, intolerance or contraindication with the prior authorized alternative Celebrex (supported by documentation from the patients chart notes/medical records/electronic claim history)

ESTRAMUSTINE PHOSPHATE SODIUM

Products Affected

- EMCYT

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

ETANERCEPT

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

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

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

ETHACRYNIC ACID

Products Affected

- *ethacrynic acid*

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

EVEROLIMUS

Products Affected

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

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

EVEROLIMUS - ZORTRESS

Products Affected

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

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

Products Affected

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

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

FENTANYL TRANSMUCOSAL AGENTS

Products Affected

- *fentanyl citrate buccal tablet, effervescent*
- FENTORA

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	6 months
Other Criteria	1) Trial of or contraindication to an oral immediate-release pain medication (such as morphine sulfate immediate-release [MSIR], Percodan, Percocet, Vicodin, Tylenol with Codeine, Dilaudid, Demerol or the generic forms of any of these), unless patient has difficulty swallowing tablets or capsules, 2) Trial of or contraindication to generic fentanyl citrate lozenge

FIDAXOMICIN

Products Affected

- DIFICID

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

FILGRASTIM

Products Affected

- NIVESTYM

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

FINGOLIMOD

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

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

FLUCYTOSINE

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

Products Affected

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

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

PA Criteria	Criteria Details
Other Criteria	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

FONDAPARINUX

Products Affected

- *fondaparinux*

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

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

FORMOTEROL

Products Affected

- *formoterol fumarate*

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

FULVESTRANT

Products Affected

- *fulvestrant*

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

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

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE

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

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

GEMCITABINE IV

Products Affected

- *gemcitabine*

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

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

GLATIRAMER ACETATE

Products Affected

- *glatiramer*
- *glatopa*

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

GOLIMUMAB - IV (NSA)

Products Affected

- SIMPONI ARIA

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

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: (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. PsA: (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. AS: (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). PJIA: (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. [NOTE: pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify for trials] RENEWAL:

PA Criteria	Criteria Details
	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. PsA/PJIA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. 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.

GOLIMUMAB - SQ

Products Affected

- SIMPONI

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	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
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: (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. PsA: (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. AS: (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). UC: (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. [NOTE: pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify for trials]

PA Criteria	Criteria Details
	RENEWAL: 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. PsA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. 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. UC: Diagnosis of moderate to severe ulcerative colitis.

GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST (LEUPROLIDE)

Products Affected

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

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

GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST (NSA)

Products Affected

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

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

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

GUSELKUMAB

Products Affected

- TREMFYA

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

HEREDITARY ANGIOEDEMA (PA)

Products Affected

- *icatibant*
- *sajazir*

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

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

HYDROCODONE ER

Products Affected

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

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

HYDROMORPHONE ER

Products Affected

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

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

IBRUTINIB

Products Affected

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

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

ILOPROST

Products Affected

- VENTAVIS

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

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

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

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

IMMUNE GLOBULIN

Products Affected

- HYQVIA

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

INSULIN GLULISINE

Products Affected

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

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

INTERFERONS FOR MULTIPLE SCLEROSIS

Products Affected

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

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

ISAVUCONAZONIUM

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	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
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Infectious Disease specialist
Coverage Duration	3 months
Other Criteria	Patient has had a trial and therapeutic failure, intolerance, or contraindication to 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	INITIAL: Patient has a diagnosis of severe recalcitrant nodular acne, treatment-resistant or scarring acne; AND Patient has had a trial and therapeutic failure with at least TWO (2) topical acne medications AND a trial of an oral tetracycline or tetracycline derivative. RENEWAL: Patient has had a relapse of severe recalcitrant nodular acne, treatment-resistant or scarring acne requiring a second treatment course; AND there is a gap of at least 2 months since completing the initial treatment course. QUANTITY RESTRICTION, Maximum 60 capsules / 30 days

ITRACONAZOLE ORAL

Products Affected

- *itraconazole*

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

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

IVABRADINE

Products Affected

- CORLANOR ORAL TABLET

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

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

LACOSAMIDE

Products Affected

- VIMPAT ORAL SOLUTION
- VIMPAT ORAL TABLET

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

LACTULOSE

Products Affected

- KRISTALOSE
- *lactulose oral packet*

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

LAPATINIB

Products Affected

- *lapatinib*

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

LASMIDITAN

Products Affected

- REYVOW

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

LEDIPASVIR/SOFOSBUVIR

Products Affected

- HARVONI

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

LENALIDOMIDE

Products Affected

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

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

LENVATINIB

Products Affected

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

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

LEVOFLOXACIN OPHTHALMIC

Products Affected

- *levofloxacin ophthalmic (eye) drops 0.5%*

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

LIDOCAINE PATCH 5%

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

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

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

LOMUSTINE

Products Affected

- GLEOSTINE

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

LUMACAFTOR-IVACAFTOR

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

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

LURASIDONE

Products Affected

- LATUDA

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

MECASERMIN

Products Affected

- INCRELEX

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

MELPHALAN

Products Affected

- *melphalan*
- *melphalan hcl*

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

MEMANTINE ORAL SOLUTION

Products Affected

- *memantine oral solution*

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

MESALAMINE

Products Affected

- *mesalamine rectal suppository*

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

MESNA

Products Affected

- MESNEX ORAL

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

METAXALONE

Products Affected

- *metaxalone*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Known tendency to drug induced, hemolytic, or other anemias. Significantly impaired renal or hepatic function.
Required Medical Information	None
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	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
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients exhibiting idiosyncratic reactions to psoralen compounds. Patients possessing a specific history of light-sensitive disease states (e.g., lupus erythematosus, porphyria cutanea tarda, erythropoietic protoporphyria, variegate porphyria, xeroderma pigmentosum, and albinism) Patients with melanoma or with a history of melanoma. Patients with invasive squamous cell carcinomas. Patients with aphakia because of the significantly increased risk of retinal damage due to the absence of lenses.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of severe, recalcitrant, disabling psoriasis; AND Patients diagnosis is supported by biopsy (submission of supporting chart notes required); AND Patients disease is not adequately responsive to other forms of therapy; AND methoxsalen will be used in conjunction with a schedule of controlled doses of long wave ultraviolet radiation.

MIDAZOLAM

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with known hypersensitivity to midazolam. Acute narrow-angle glaucoma
Required Medical Information	None
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	12 months
Other Criteria	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
Covered Uses	All FDA approved indications.
Exclusion Criteria	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
Required Medical Information	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.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist, physiatrist, neurologist, or pain management specialist.
Coverage Duration	12 months
Other Criteria	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.

MIRABEGRON

Products Affected

- MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Known hypersensitivity to mirabegron.
Required Medical Information	None
Age Restrictions	3 years of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	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

Products Affected

- LYSODREN

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

MODAFINIL

Products Affected

- *modafinil*

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

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

NALTREXONE MICROSPHERES

Products Affected

- VIVITROL

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

PA Criteria	Criteria Details
Other Criteria	ALCOHOL DEPENDENCE 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. OPIOID DEPENDENCE 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

NILOTINIB

Products Affected

- TASIGNA

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

NILUTAMIDE

Products Affected

- *nilutamide*

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

NITAZOXANIDE

Products Affected

- ALINIA ORAL SUSPENSION FOR RECONSTITUTION
- *nitazoxanide*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Prior hypersensitivity to nitazoxanide
Required Medical Information	None
Age Restrictions	Tablets: 12 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Giardiasis or Cryptosporidiosis: 3 days
Other Criteria	A. GIARDIASIS (1) Prescriber attests patient has a diagnosis of diarrhea caused by Giardia lamblia (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 Cryptosporidium parvum (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
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: ACROMEGALY Baseline growth hormone (GH) and/or IGF-I blood levels are submitted for documentation. RENEWAL: ACROMEGALY Patient has documented disease response confirmed by reduction of growth hormone (GH) and/or IGF-I blood levels from baseline AND Serum insulin-like growth factor-I (IGF-I) levels remain outside normal limits.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	INITIAL: ACROMEGALY: Patients has had an inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses. ALL DIAGNOSES: REQUESTS FOR SANDOSTATIN LAR: Patient must have responded to and tolerated octreotide injection.

OLAPARIB

Products Affected

- LYNPARZA ORAL TABLET 100 MG, 150 MG

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

OLSALAZINE

Products Affected

- DIPENTUM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Known or suspected hypersensitivity to salicylates, aminosalicylates, or their metabolites
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in conjunction with, a gastroenterologist
Coverage Duration	12 months
Other Criteria	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

Products Affected

- XOLAIR

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

PA Criteria	Criteria Details
Other Criteria	Xolair is considered medically necessary for the following conditions: A. Nasal polyps in adult patients 18 years of age and older when the following criteria are met; both: a. Inadequate response to nasal corticosteroids b. Xolair will be utilized as add-on maintenance treatment B. Chronic idiopathic uticaria for member greater than 12 years of age; both: a. Unknown cause b. Unresponsive to H1 antihistamine treatment C. Moderate-to-severe, persistent asthma for members 6 years and older when the following criteria are met; all: a. Evidence of specific allergic sensitivity confirmed by positive skin test to perennial aeroallergens or RAST test b. Failure to respond to treatment for moderate, persistent asthma for greater than or equal to 6 months with either: i. Moderate-dose ICS and long-acting beta-agonist ii. Low-moderate dose ICS, long-acting inhaled beta2-agonist, and leukotriene modifiers 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 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. e. Evidence of reversible disease (i.e., greater than or equal to 12% improvement in FEV1 following beta2-agonist administration

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
Covered Uses	All FDA approved indications.
Exclusion Criteria	Moderate and severe hepatic impairment, Paralytic ileus
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	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

Products Affected

- IBRANCE

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

PALIPERIDONE

Products Affected

- INVEGA SUSTENNA

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

PALIPERIDONE TAB ER

Products Affected

- *paliperidone*

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

PALIVIZUMAB

Products Affected

- SYNAGIS

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

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

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

PANOBINOSTAT

Products Affected

- FARYDAK

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	RENEWAL: Tolerated the first 8 cycles of therapy without any severe or medically significant toxicity

PARICALCITOL

Products Affected

- *paricalcitol oral*

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

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

PAROXETINE SUSPENSION

Products Affected

- *paroxetine hcl oral suspension*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	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.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic 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

Products Affected

- SIGNIFOR

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	INITIAL: 6 MONTHS. RENEWAL: 12 months. IL: 12 months
Other Criteria	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

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	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). CUSHINGS DISEASE: Patient has had an inadequate response to surgery OR surgery is not an option.

PAZOPANIB

Products Affected

- VOTRIENT

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

PCSK9

Products Affected

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

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

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

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

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

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

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

Products Affected

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

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

PEGFILGRASTIM

Products Affected

- NYVEPRIA
- ZIEXTENZO

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

PEGVISOMANT

Products Affected

- SOMAVERT

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

PENICILLAMINE

Products Affected

- *penicillamine oral tablet*

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

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

PENTOSAN POLYSULFATE

Products Affected

- ELMIRON

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

PERAMPANEL

Products Affected

- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	Primary Generalized Tonic-Clonic Seizures: 12 years of age or older, Partial-onset seizures: 4 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	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

PHOSPHATE BINDERS

Products Affected

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

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

PIMECROLIMUS

Products Affected

- *pimecrolimus*

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

POMALIDOMIDE

Products Affected

- POMALYST

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

PONATINIB

Products Affected

- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 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	None

POSACONAZOLE

Products Affected

- *posaconazole oral tablet,delayed release (dr/ec)*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	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).
Required Medical Information	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
Age Restrictions	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
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Treatment of invasive Aspergillosis: 3 months All others: 1 month
Other Criteria	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 hematopoetic 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

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Hypoglycemia unawareness. Confirmed gastroparesis.
Required Medical Information	Hgb A1C
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	12 months
Other Criteria	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
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Undiagnosed abnormal genital bleeding.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	INITIAL: 3 months. RENEWAL: 12 months IL: 12 months
Other Criteria	INITIAL: 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). RENEWAL: Patient has had a response to therapy (decrease in symptoms of dyspareunia) as determined by prescriber. INITIAL/RENEWAL: Dose must not exceed 1 vaginal insert daily

PROCARBAZINE

Products Affected

- MATULANE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients with inadequate marrow reserve as demonstrated by bone marrow aspiration.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Prescribed by, or in consultation with, a Hematologist or Oncologist
Coverage Duration	12 months
Other Criteria	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%)

Products Affected

- CRINONE VAGINAL GEL 4 %

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	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. 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.

PYRAZINAMIDE

Products Affected

- *pyrazinamide*

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

PYRIDOSTIGMINE

Products Affected

- *pyridostigmine bromide oral syrup*

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

RANOLAZINE

Products Affected

- *ranolazine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Concurrent use with strong inhibitors of CYP3A and inducers of CYP3A Patients with clinically significant hepatic impairment
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist
Coverage Duration	12 months
Other Criteria	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.

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	KISQALI-FEMARA CO-PACK: 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. KISQALI: 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.

RIFABUTIN

Products Affected

- *rifabutin*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: Hypersensitivity to rifabutin or to any other rifamycins.
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	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 550 MG

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

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

RILONACEPT

Products Affected

- ARCALYST

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

RIMEGEPANT

Products Affected

- NURTEC ODT

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

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

RIOCIGUAT

Products Affected

- ADEMPAS

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

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

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI

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

ROLAPITANT

Products Affected

- VARUBI ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Patients taking CYP2D6 substrates with a narrow therapeutic index, such as thioridazine and pimozide.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	6 months IL: 12 months
Other Criteria	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. Highly Emetogenic Chemotherapy (HEC) includes: Carboplatin, Carmustine, Cisplatin, Cyclophosphamide, Dacarbazine, Doxorubicin, Epirubicin, Ifosfamide, Mechlorethamine,Streptozocin. 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 The following regimens can be considered HEC: FOLFOX.

RUXOLITINIB

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	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
Prescriber Restrictions	None
Coverage Duration	MYELOFIBROSIS: INIT: 6 mo. RNWL: 12 mo. PV, ACUTE GvHD, CHRONIC GvHD: 12 mo. IL: 12 mo
Other Criteria	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.

SECUKINUMAB

Products Affected

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

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

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

SELEXIPAG

Products Affected

- UPTRAVI ORAL

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

SELINEXOR

Products Affected

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

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

SILODOSIN

Products Affected

- *silodosin*

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

SOFOSBUVIR/VELPATASVIR

Products Affected

- EPCLUSA

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

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

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

SOMATROPIN

Products Affected

- NORDITROPIN FLEXPRO

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 FLEXPRO, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, ZOMACTON: Prescribed for athletic enhancement, anti-aging purposes, or idiopathic short stature.

PA Criteria	Criteria Details
Required Medical Information	INITIAL: HIV WASTING/CACHEXIA: 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 PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD): (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. TURNER SYNDROME, NOONAN SYNDROME, SMALL GESTATIONAL AGE (SGA), SHOX DEFICIENCY: (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. PRADER-WILLI SYNDROME (PWS): (1) Confirmed genetic diagnosis of PWS. GROWTH FAILURE SECONDARY TO CHRONIC KIDNEY DISEASE (CKD): (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
Age Restrictions	None

PA Criteria	Criteria Details
Prescriber Restrictions	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
Coverage Duration	INIT/RNWL: SEROSTIM: 12 wk ZORBTIVE: max 4 wk/lifetime Others: 12 mo

PA Criteria	Criteria Details
Other Criteria	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. SHORT BOWEL SYN: (1) On specialized nutritional support, AND (2) Req. is for Zorbtive. 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 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 PRADER-WILLI SYN: (1) Trial of/CI to Norditropin (unless req for Norditropin). (2) Req. is for Genotropin, Norditropin Flexpro, Omnitrope 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 SHOX DEFICIENCY: Req. is for Humatrope, Zomacton NOONAN SYN: Req. is for Norditropin 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

PA Criteria	Criteria Details
	GROWTH FAILURE SECONDARY TO CKD: (1) Has NOT undergone a renal transplantation, and (2) Req. is for Nutropin AQ. 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 SHORT BOWEL SYN: (1) Has NOT been on med for 4 wks 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. 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. PRADER-WILLI SYN: (1) Improvement in body composition. 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.

SORAFENIB

Products Affected

- NEXAVAR

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

SUCRALFATE

Products Affected

- *sucralfate oral suspension*

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

SUMATRIPTAN

Products Affected

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

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

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

SUNITINIB

Products Affected

- *sunitinib*

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

TEMOZOLOMIDE - IV

Products Affected

- TEMODAR INTRAVENOUS

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

TEMOZOLOMIDE-PO

Products Affected

- *temozolomide*

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

TEMSIROLIMUS

Products Affected

- *temsirolimus*

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

TENOFOVIR ALAFENAMIDE

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	INITIAL: A. Patient has diagnosis of Chronic Hepatitis B (HBsAg positive or negative for at least 6 months); AND B. There is documented evidence of active viral replication (HBeAG+ and HBV DNAgreater than 100,000 copies/mL); AND 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. RENEWAL: 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 B. Patient has been tested for and remains HIV-1 negative.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a Gastroenterologist, Hepatologist, or Infectious Disease Specialist.
Coverage Duration	INITIAL/RENEWAL:12 months.

PA Criteria	Criteria Details
Other Criteria	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

Products Affected

- AUBAGIO

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

TESTOSTERONE

Products Affected

- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*

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

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

TETRABENAZINE

Products Affected

- *tetrabenazine*

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

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

TEZACAFTOR/IVACAFTOR

Products Affected

- SYMDEKO

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

THALIDOMIDE

Products Affected

- THALOMID

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

THIOGUANINE

Products Affected

- TABLOID

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

TOBRAMYCIN INHALED

Products Affected

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

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

TOCILIZUMAB - IV (NSA)

Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	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.
Prescriber Restrictions	RA/PJIA: Prescribed by or in consultation with a rheumatologist. SJIA: Prescribed by or in consultation with a rheumatologist, dermatologist, or immunologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months. IL: 12 months

PA Criteria	Criteria Details
Other Criteria	INITIAL: RA: (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. PJIA: (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. SJIA: Trial of or contraindication to ONE DMARD (disease-modifying antirheumatic drug), such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. [NOTE: pharmaceutical samples acquired from the prescriber or manufacturer assistance program do not qualify for trials] RENEWAL: RA/PJIA: Experienced or maintained a 20% or greater improvement in tender joint count or swollen joint count while on therapy. SJIA: (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)

TOCILIZUMAB - SQ

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

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

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

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

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

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

TOLCAPONE

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	INITIAL/RENEWAL: 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.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	INITIAL: 3 months. RENEWAL: 12 months. IL: 12 months
Other Criteria	INITIAL: 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. RENEWAL: 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

Products Affected

- *toremifene*

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

TRAMADOL_ACETAMINOPHEN HYDROCHLORIDE

Products Affected

- *tramadol-acetaminophen*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications.
Exclusion Criteria	Previous hypersensitivity to tramadol, acetaminophen, or other opioids. Post-operative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy. Significant respiratory depression. Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment. Patients with known or suspected gastrointestinal obstruction, including paralytic ileus. Concurrent use of monoamine oxidase inhibitors (MAOIs) or use within the last 14 days.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	30 days.
Other Criteria	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.

TRAMETINIB DIMETHYL SULFOXIDE

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

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

TREPROSTINIL

Products Affected

- ORENITRAM

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

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

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

TRETINOIN ORAL

Products Affected

- *tretinoin (antineoplastic)*

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

TRIAMCINOLONE AEROSOL

Products Affected

- *triamcinolone acetonide topical aerosol*

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

TRIFLURIDINE EYE DROPS

Products Affected

- *trifluridine*

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

UBROGEPANT

Products Affected

- UBRELVY

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

UPADACITINIB

Products Affected

- RINVOQ

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

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

USTEKINUMAB

Products Affected

- STELARA SUBCUTANEOUS

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

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

VALGANCICLOVIR

Products Affected

- *valganciclovir*

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

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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

VEMURAFENIB

Products Affected

- ZELBORAF

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

VORICONAZOLE

Products Affected

- *voriconazole oral*

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

INDEX