Prior Authorization Detail
Texas July 2023

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.

ACITRETIN

Products Affected

- ACITRETIN 10 MG CAPSULE
- ACITRETIN 17.5 MG CAPSULE
- ACITRETIN 25 MG CAPSULE

PA Criteria	Criteria Details
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	N/A
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.
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ACTEMRA (TOCILIZUMAB) SQ

Products Affected

- ACTEMRA 162 MG/0.9 ML SYRINGE P/F, SUV
- ACTEMRA ACTPEN 162 MG/0.9 ML

PA Criteria	Criteria Details
Exclusion Criteria	1. Concurrent use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD). Note: This does NOT exclude the use of conventional synthetic DMARDs (e.g., methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine) in combination with Actemra subcutaneous, 2. COVID-19 (Coronavirus Disease 2019) Note: This includes requests for cytokine release syndrome associated with COVID-19. 3. Crohns Disease
Required Medical Information	Initial: Giant Cell Arteritis: Patient has tried one systemic corticosteroid. Interstitial Lung Disease Associated with Systemic Sclerosis: Patient meets ALL of the following (i, ii, and iii): i. Patient has elevated acute phase reactants, defined as at least ONE of the following (a, b, or c): a) CRP greater than or equal to 6 mg/mL, OR b) ESR greater than or equal to 28 mm/h, OR c) Platelet count greater than or equal to 330 x 109/L, AND ii. FVC is greater than 55% of the predicted value, AND iii. Diagnosis is confirmed by high-resolution computed tomography. Polyarticular JIA: ONE of the following (a, b, c, or d): a) Patient has tried one other systemic therapy for this condition OR b) Patient will be starting on Actemra subcutaneous concurrently with methotrexate, sulfasalazine, or leflunomide OR c) Patient has an absolute contraindication to methotrexate, sulfasalazine, or leflunomide OR d) Patient has aggressive disease, as determined by the prescriber AND ONE of the following conditions (a or b): a) Patient has tried Humira OR b) Per the prescriber, the patient has heart failure or a previously treated lymphoproliferative disorder. RA: Patient has tried one conventional synthetic DMARD for at least 3 months AND ONE of the following conditions (a or b): a) Patient has tried Humira OR b) Per the prescriber, the patient has heart failure or a previously treated lymphoproliferative disorder. Systemic JIA: Patient has tried one other systemic therapy for this condition. Polymyalgia Rheumatica: Patient has tried one systemic corticosteroid. Renewal: Giant Cell Arteritis: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as decreased headache, scalp, or jaw pain. decreased fatigue, and/or improved vision.

PA Criteria	Criteria Details
Age Restrictions	Initial/Renewal: Interstitial Lung Disease Associated with Systemic Sclerosis: 18 years of age and older
Prescriber Restrictions	Initial: Giant Cell Arteritis, Polyarticular Juvenile Idiopathic Arthritis, Rheumatoid Arthritis, Systemic Juvenile Idiopathic Arthritis, Polymyalgia Rheumatica: Prescribed by or in consultation with a rheumatologist. Initial/Renewal: Interstitial Lung Disease Associated with Systemic Sclerosis: Pulmonologist or a rheumatologist.
Coverage Duration	Initial: Giant Cell Arteritis, JIA, Polymyalgia Rheumatica: 6 mos. SSc-ILD: 12 mos. Renewal: 12 mos
Other Criteria	SSc-ILD: Patient has had a beneficial response to therapy over the previous 1 year while receiving Actemra. Polyarticular JIA: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as improvement in limitation of motion, less joint pain or tenderness, decreased duration of morning stiffness or fatigue, improved function or activities of daily living AND patient has tried Humira OR Per the prescriber, the patient has heart failure or a previously treated lymphoproliferative disorder OR Per the prescriber, the patient has been established on Actemra intravenous for at least 90 days OR Patient has been established on Actemra subcutaneous for at least 90 days and prescription claims indicates at least a 90-day supply of Actemra subcutaneous was dispensed within the past 130 days [verification required] if claims history is not available, according to the prescriber [verification required]. RA: Patient has been on therapy for at least 6 months AND Patient had a beneficial clinical response when assessed by at least one objective measure OR b) Patient had an improvement in at least one symptom, such as decreased joint pain, morning stiffness, or fatigue. improved function or activities of daily living. decreased soft tissue swelling in joints or tendon sheaths AND patient has tried Humira OR Per the prescriber, the patient has heart failure or a previously treated lymphoproliferative disorder OR Per the prescriber, the patient has been established on Actemra intravenous for at least 90 days OR Patient has been established on Actemra subcutaneous for at least 90 days and prescription claims indicates at least a 90-day supply of Actemra subcutaneous was dispensed within the past 130 days [verification required] if claims history is not available, according to the prescriber [verification required]. Systemic JIA: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as less

PA Criteria	Criteria Details
	joint pain/tenderness, stiffness, or swelling. decreased fatigue. improved function or activities of daily living. Polymyalgia Rheumatica: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as decreased shoulder, neck, upper arm, hip, or thigh pain or stiffness. improved range of motion AND/or decreased fatigue.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Polymyalgia Rheumatica

ACYCLOVIR OINTMENT

Products Affected

- ACYCLOVIR 5% OINTMENT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 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. HERPES SIMPLEX VIRUS (HSV): Patient has non-life-threatening mucocutaneous HSV infection AND Patient is immunocompromised.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADEFOVIR

Products Affected

- ADEFOVIR DIPIVOXIL 10 MG TAB

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALBENDAZOLE

Products Affected

- ALBENDAZOLE 200 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
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 hydatid disease of the liver, lung, and peritoneum caused by larval form of the dog tapeworm (Echinococcus granulosus).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALOSETRON

Products Affected

- ALOSETRON HCL 0.5 MG TABLET
- ALOSETRON HCL 1 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: Male patients. Constipation. History of chronic or severe constipation or with a history of sequelae from constipation. History of intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. History of ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state. Crohns disease, ulcerative colitis, and/or diverticulitis. Severe hepatic impairment. Concomitant administration with fluvoxamine.
Required Medical Information	N/A
Age Restrictions	18 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	Duration of therapy: ONE MONTH. Renewal: 6 months.
Other Criteria	INITIAL: Patient has a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) defined by documentation of at least ONE of the following: (1) frequent and severe abdominal pain/discomfort, (2) frequent bowel urgency or fecal incontinence, (3) disability or restriction of daily activities due to IBS AND Patient has chronic IBS symptoms generally lasting 6 months or longer AND Patient has had anatomic or biochemical abnormalities of the gastrointestinal tract ruled out AND Patient has not responded adequately to conventional therapy including a trial and therapeutic failure of: (1) dietary changes (including fiber), stress reduction, and other behavioral changes, (2) antidiarrheals (e.g., loperamide, diphenoxylate and atropine), (3) antidepressants (e.g., desipramine, imipramine), (4) antispasmodics (e.g., dicyclomine, hyoscyamine). RENEWAL: Prescriber attests to clinical notes demonstrating adequate control of IBS symptoms.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

AMINOCAPROIC ACID

Products Affected

- AMINOCAPROIC ACID 1,000 MG TAB
- AMINOCAPROIC ACID 500 MG TAB

PA Criteria	Criteria Details
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 ONE of the following conditions: 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ANABOLIC STEROIDS

Products Affected

- OXANDROLONE 10 MG TABLET
- OXANDROLONE 2.5 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: 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 f) Pregnancy
Required Medical Information	INITIAL: CACHEXIA ASSOCIATED WITH AIDS: Patient is on anti-retroviral therapy ALL OTHER INDICATIONS: None RENEWAL: Prescriber attests to improvement and continued need for treatment
Age Restrictions	N/A
Prescriber Restrictions	CACHEXIA ASSOCIATED WITH AIDS: Prescribed by or in consultation with a gastroenterologist, nutritional Support Specialist (SBS) or Infectious Disease specialist
Coverage Duration	6 months
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Cachexia associated with AIDS, Turners syndrome, Adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, Bone pain accompanying osteoporosis, Adjunctive therapy to offset protein catabolism associated with prolonged administration of corticosteroids

ANTIEPILEPTICS - LACOSAMIDE CARE VALUE POLICY

Products Affected

- LACOSAMIDE 10 MG/ML SOLUTION
- LACOSAMIDE 100 MG TABLET
- LACOSAMIDE 150 MG TABLET
- LACOSAMIDE 200 MG TABLET
- LACOSAMIDE 50 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Treatment of partial-onset seizures: 1 month of age and older. Adjunctive therapy in the treatment of primary generalized tonic-clonic seizures: 4 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Trial of generic lacosamide tablets, generic lacosamide oral solution
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

APOMORPHINE

Products Affected

- APOMORPHINE 30 MG/3 ML CARTRDG INNER, SUV

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with 5HT2 antagonists, including antiemetics (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron). Hypersensitivity to sodium metabisulfite.
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist
Coverage Duration	12 months
Other Criteria	INITIAL: (1) Patient has diagnosis of Advanced Parkinsons Disease with acute, intermittent hypomobility, (off) episodes AND (2) Apokyn will be used in combination with a levodopa containing product AND another anti-Parkinsons agent (i.e. dopamine agonist or COMT inhibitor). RENEWAL: (1) Patient has diagnosis of Advanced Parkinsons Disease AND (2) Apokyn will be used in combination with a levodopa containing product AND another anti-Parkinsons agent (i.e. dopamine agonist or COMT inhibitor) AND (3) Patient has experienced a reduction in hypomobility, (off) episodes.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ARIPIPRAZOLE

Products Affected

- ABILIFY MAINTENA ER 300 MG SYR
- ABILIFY MAINTENA ER 300 MG VL OUTER,SUV
- ABILIFY MAINTENA ER 400 MG SYR SUV
- ABILIFY MAINTENA ER 400 MG VL OUTER,SUV

PA Criteria	Criteria Details
Exclusion Criteria	History of a hypersensitivity reaction to aripiprazole.
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	A. SCHIZOPHRENIA: (1) Patient has a diagnosis of schizophrenia AND (2) There is documentation supporting that patient had a trial and therapeutic failure, intolerance, or contraindication to the formulary alternative: aripiprazole tablet OR B. BIPOLAR I DISORDER: (1) Patient has a diagnosis of bipolar I disorder AND (2) Abilify Maintena will be used as maintenance monotherapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ARMODAFINIL

Products Affected

- ARMODAFINIL 150 MG TABLET
- ARMODAFINIL 200 MG TABLET
- ARMODAFINIL 250 MG TABLET
- ARMODAFINIL 50 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Patients with known hypersensitivity to modafinil
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	A. Patient has ONE of the following diagnoses: 1. Narcolepsy 2. Shift work sleep disorder 3. Obstructive Sleep Apnea. B. NARCOLEPSY: Patient has a diagnosis of narcolepsy supported by a documented sleep study, AND documentation has been provided to confirm that the diagnosis of narcolepsy is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, etc.) or another general medical condition. C. SHIFT WORK SLEEP DISORDER: Documentation has been provided to confirm that the patient is experiencing excessive sleepiness and working a minimum of five (or more) overnight shifts per month, AND documentation has been provided to confirm that the diagnosis is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, etc.). D. OBSTRUCTIVE SLEEP APNEA: Patient has a diagnosis of obstructive sleep apnea supported by a documented sleep study .
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ASENAPINE

Products Affected

- ASENAPINE 10 MG TABLET SL OUTER
- ASENAPINE 2.5 MG TABLET SL OUTER
- ASENAPINE 5 MG TABLET SL OUTER

PA Criteria	Criteria Details
Exclusion Criteria	Known hypersensitivity to asenapine
Required Medical Information	N/A
Age Restrictions	Bipolar I disorder - ONE of the following: i. Prescribed for acute monotherapy of manic or mixed episodes in a patient 10 years of age or older, OR ii. Prescribed as an adjunctive treatment to lithium or valproate in a patient 18 years of age or older, OR iii. Prescribed as maintenance monotherapy treatment in a patient 18 years of age or older. Schizophrenia - 18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	(1) Patient has a diagnosis of bipolar disorder OR schizophrenia, AND (2) Documentation has been submitted to confirm the patient has had a trial and failure, intolerance, or contraindication to at least TWO formulary alternatives including risperidone ODT, risperidone, quetiapine, olanzapine, ziprasidone (Note: patients chart notes/medical records/electronic claim history required for documentation).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ATOVAQUONE

Products Affected

- ATOVAQUONE 750 MG/5 ML SUSP

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: 1. Treatment of more severe episodes of PCP 2. Patients who are failing therapy with TMP-SMX for PCP.
Required Medical Information	INITIAL/RENEWAL: PROPHYLAXIS OF PCP: Patients with HIV have one of the following: 1. Documented CD4 count of less than 200 cells/mm3 within the last 3 months OR 2. Documentation to confirm that the patient had an episode of PCP that occurred at a CD4 count greater than 200cells/mm3 while the patient was on antiretroviral therapy.
Age Restrictions	13 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Infectious Disease specialist, oncologist, or HIV specialist.
Coverage Duration	INITIAL: Treatment of PCP: 21 days. Prophylaxis of PCP: 12mos. RENEWAL: Prophylaxis of PCP: 12mos
Other Criteria	INITIAL: TREATMENT OF PCP: 1. Patient has a diagnosis of mild-to-moderate PCP, 2. Patient has a documented trial and therapeutic failure, intolerance or contraindication to trimethoprim/sulfamethoxazole (TMP-SMX), 3. Patient has a documented trial and therapeutic failure, intolerance or contraindication to dapsone. PROPHYLAXIS OF PCP: 1. Documentation to confirm that the patient is immunocompromised and requires prevention of Pneumocystis carinii pneumonia (PCP), 2. Patient has a documented trial and therapeutic failure, intolerance or contraindication to trimethoprim/sulfamethoxazole (TMP-SMX), 3. Patient has a documented trial and treatment failure, intolerance or contraindication to dapsone. RENEWAL: PROPHYLAXIS OF PCP: 1. Prescriber attests that patient is responding positively to therapy, 2. Prescriber provides documentation to confirm that the patient has been compliant on the requested medication.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AZITHROMYCIN

Products Affected

- AZASITE 1% EYE DROPS

PA Criteria	Criteria Details
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 had a trial and therapeutic failure, intolerance, or contraindication to a trial of 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BECAPLERMIN

Products Affected

- REGRANEX 0.01% GEL

PA Criteria	Criteria Details
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	N/A
Age Restrictions	16 years of age and older.
Prescriber Restrictions	N/A
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 Patient wound is free from infection.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BENRALIZUMAB

Products Affected

- FASENRA 30 MG/ML SYRINGE P/F,SDV
- FASENRA PEN 30 MG/ML SUV

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Xolair, Dupixent, or another anti-IL5 biologic (such as Nucala, Cinqair, etc.) for the treatment of asthma
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by, or given in consultation with, a physician specializing in pulmonary medicine or allergy medicine
Coverage Duration	Initial: 12 weeks, Renewal: 12 months
Other Criteria	Initial: A. Patient has severe asthma with an eosinophilic phenotype, B. Patient has a documented blood eosinophil level of at least 150 cells/mcL within the past 12 months, C. Documentation has been submitted to confirm that the patient is currently being treated with BOTH of the following: a medium, high-dose, or a maximally tolerated dose of an inhaled corticosteroid AND at least one other maintenance medication which includes a long-acting inhaled beta2-agonist (such as formoterol, salmeterol), long acting muscarinic antagonist (such as tiotropium), leukotriene receptor antagonist (such as montelukast), theophylline, or oral corticosteroid, D. Patient has ONE of the following: 1. Patient has experienced at least ONE asthma exacerbation requiring systemic corticosteroid burst lasting at least 3 days within the past 12 months 2. Patient has experienced at least ONE serious exacerbation requiring hospitalization or emergency room visit within the past 12 months 3. Patient has poor symptom control despite current therapy as evidenced by at least THREE of the following within the past 4 weeks: a. Daytime asthma symptoms more than twice per week b. Any night waking due to asthma c. Use of a short-acting inhaled beta2-agonist reliever (such as albuterol) for symptoms more than twice per week d. Any activity limitation due to asthma. Renewal: A. Patient will continue to use BOTH of the following: an inhaled corticosteroid AND at least one other

PA Criteria	Criteria Details
	maintenance medication such as a long-acting inhaled beta2-agonist (such as formoterol, salmeterol), a long-acting muscarinic antagonist (such as tiotropium), a leukotriene receptor antagonist (such as montelukast), theophylline, or oral corticosteroid, B. Patient has shown a clinical response as evidenced by ONE of the following: 1. Reduction in asthma exacerbation from baseline 2. Decreased use of rescue medications 3. Increase in percent predicted FEV1 from pretreatment baseline 4. Reduction in severity or frequency of asthma.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BEPOTASTINE

Products Affected

- BEPOTASTINE 1.5% EYE DROP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Patient has had a trial and therapeutic failure to at least TWO of the following: azelastine ophthalmic solution cromolyn sodium ophthalmic solution epinastine ophthalmic solution olopatadine 0.1% ophthalmic solution.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BESIFLOXACIN

Products Affected

- BESIVANCE 0.6% SUSP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
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	The patients diagnosis is caused by susceptible isolates of the following bacteria: Aerococcus viridans, CDC coryneform group G, Corynebacterium pseudodiphtheriticum, Corynebacterium striatum, Haemophilus influenzae, Moraxella catarrhalis, Moraxella lacunata, Pseudomonas aeruginosa, Staphylococcus aureus, Staphylococcus epidermidis, Staphylococcus hominis, Staphylococcus lugdunensis, Staphylococcus warneri, Streptococcus mitis group, Streptococcus oralis, Streptococcus pneumoniae, Streptococcus salivarius AND 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BETAINE

Products Affected

- BETAINE 1 GRAM/SCOOP POWDER

PA Criteria	Criteria Details
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	A. Patient has a diagnosis of homocystinuria AND B. Cystadane will be used to decrease elevated homocysteine blood concentrations AND C. Patient has cystathionine beta-synthase deficiency, 5,10-methylenetetrahydrofolate reductase deficiency, or cobalamin cofactor metabolism defect.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BETAXOLOL

Products Affected

- BETOPTIC S 0.25% EYE DROP

PA Criteria	Criteria Details
Exclusion Criteria	Patients with sinus bradycardia, greater than a first degree atrioventricular block, cardiogenic shock, or patients with overt cardiac failure.
Required Medical Information	N/A
Age Restrictions	18 years of age and older.
Prescriber Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BREXPIPRAZOLE

Products Affected

- REXULTI 0.25 MG TABLET
- REXULTI 0.5 MG TABLET
- REXULTI 1 MG TABLET
- REXULTI 2 MG TABLET
- REXULTI 3 MG TABLET
- REXULTI 4 MG TABLET

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BRIMONIDINE

Products Affected

- BRIMONIDINE 0.33% GEL PUMP

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to brimonidine
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 persistent (nontransient) erythema of rosacea AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic topical metronidazole.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CALCITONIN SALMON

Products Affected

- CALCITONIN-SALMON 400 UNIT/2 ML

PA Criteria	Criteria Details
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: Documentation of patients corrected total serum calcium is greater than or equal to 12 mg/dl OR there is documentation that corrected total serum calcium is greater than or equal to 6 mEq/L.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Hypercalcemia: 1 month. All others: 12 months
Other Criteria	A. Patient has ONE of the following diagnoses: 1. Pagets Disease of Bone 2. Hypercalcemia 3. Postmenopausal osteoporosis B. For Pagets Disease of Bone: 1. Patient has a diagnosis of symptomatic Pagets disease of bone AND 2. Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO (2) oral bisphosphonates C. For hypercalcemia: 1. Patient has a documented diagnosis of hypercalcemia D. For postmenopausal osteoporosis: 1. Patient has had a trial and therapeutic failure, intolerance, or contraindication to a bisphosphonate or selective estrogen- receptor modulator (SERM) AND 2. Patient has had a trial and therapeutic failure, intolerance, or contraindication to calcitonin(salmon) nasal spray AND 3. 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CALCITRIOL OINTMENT

Products Affected

- CALCITRIOL 3 MCG/G OINTMENT

PA Criteria	Criteria Details
Exclusion Criteria	Patients with known or suspected disorders of calcium metabolism.
Required Medical Information	N/A
Age Restrictions	2 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	MILD TO MODERATE PLAQUE PSORIASIS: Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to a generic topical steroid (e.g., betamethasone dipropionate, clobetasol propionate, desoximetasone, or fluocinonide) AND Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to topical calcipotriene.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CALCIUM ACETATE

Products Affected

- PHOSLYRA 667 MG/5 ML SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Patients with hypercalcemia
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist
Coverage Duration	12 months
Other Criteria	Patient has a 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 AND Documentation of laboratory test results for 2 to 3 consecutive months been submitted to confirm that the patient's phosphorus level is GREATER THAN 4.5mg/dl OR calcium levels are above 9.6
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CEVIMELINE

Products Affected

- CEVIMELINE HCL 30 MG CAPSULE

PA Criteria	Criteria Details
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	Cevimeline will be used to treat symptoms of dry mouth AND Patient has had a documented trial and failure, intolerance, or contraindication to pilocarpine tablets.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CHLORAMBUCIL

Products Affected

- LEUKERAN 2 MG TABLET

PA Criteria	Criteria Details
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 or 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CINACALCET

Products Affected

- CINACALCET HCL 30 MG TABLET
- CINACALCET HCL 60 MG TABLET
- CINACALCET HCL 90 MG TABLET

PA Criteria	Criteria Details
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 or older
Prescriber Restrictions	None
Coverage Duration	INITIAL: 3 months, FIRST RENEWAL: 6 months, ADDITIONAL RENEWALS: 12 months
Other Criteria	INITIAL: SECONDARY HYPERPARATHYROIDISM: Patient is currently on dialysis AND Patient has had a documented trial and therapeutic failure, intolerance or contraindication to calcium acetate or a sevelamer carbonate AND meets one of the following: 1. Patient has had a documented trial and therapeutic failure to Vitamin D/Vitamin D analog (i.e., calcitriol, Hectorol, etc.), OR 2. Patient has a documented intolerance or contraindication to Vitamin D/Vitamin D analog (i.e., calcitriol, Hectorol, etc.) AND Patient has a documented diagnosis of secondary hyperparathyroidism due to chronic kidney disease. INITIAL: PARATHYROID CARCINOMA Patient has a documented diagnosis of hypercalcemia due to parathyroid carcinoma. INITIAL: PRIMARY HYPERPARATHYROIDISM Patient has a documented diagnosis of severe hypercalcemia due to primary hyperparathyroidism AND Patient is unable to undergo parathyroidectomy.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CIPROFLOXACIN/HYDROCORTISONE

Products Affected

- CIPRO HC OTIC SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	1 year of age and older
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	A. Patient has a diagnosis of acute otitis externa B. Patients diagnosis is due to susceptible strains of Pseudomonas aeruginosa, Staphylococcus aureus, or Proteus mirabilis C. 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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CLOBAZAM

Products Affected

- CLOBAZAM 10 MG TABLET
- CLOBAZAM 2.5 MG/ML SUSPENSION
- CLOBAZAM 20 MG TABLET

PA Criteria	Criteria Details
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	A. Patient has a documented diagnosis of seizures associated with Lennox-Gastaut syndrome (Note: Chart notes/medical records required for documentation), AND documentation has been provided to confirm that the patient is currently receiving treatment with at least one other antiepileptic medication (for example, but not limited to: carbamazepine, levetiracetam) (Note: Chart notes/medical records required for documentation), AND Patient has had a documented trial and therapeutic failure, intolerance or contraindication to one of the following: lamotrigine, topiramate, or valproate (Note: Chart notes/medical records/electronic claim history required for documentation), OR B. Patient has a documented diagnosis of refractory partial onset seizures (defined as four or more uncontrolled seizures per month) (Note: Chart notes/medical records required for documentation), AND documentation has been provided to confirm that the patient is currently receiving treatment with at least one other antiepileptic medication (Note: Chart notes/medical records required for documentation), AND Patient has had a documented trial and therapeutic failure, intolerance or contraindication to at least TWO antiepileptic drugs (e.g., lamotrigine, topiramate, or valproate) (Note: Chart notes/medical records/electronic claim history).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	Refractory partial onset seizures

COLISTIN/HYDROCORTISONE/NEOMYCIN/THONZONIUM

Products Affected

- CORTISPORIN-TC EAR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	The external auditory canal disorder is suspected or known to be due to cutaneous viral infection (such as: 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 or 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CYCLOSPORINE SOLUTION

Products Affected

- SANDIMMUNE 100 MG/ML SOLN

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CYSTEAMINE

Products Affected

- CYSTAGON 150 MG CAPSULE
- CYSTAGON 50 MG CAPSULE

PA Criteria	Criteria Details
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 (normal 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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DALFAMPRIDINE

Products Affected

- DALFAMPRIDINE ER 10 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: (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 or older
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 Indication of multiple sclerosis (MS), AND (2) Ampyra is being used to improve walking, (3)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 (4) 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DANAZOL

Products Affected

- DANAZOL 100 MG CAPSULE
- DANAZOL 200 MG CAPSULE
- DANAZOL 50 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	Undiagnosed abnormal genital bleeding, Markedly impaired hepatic, renal, or cardiac function, Pregnancy, Breast feeding, Porphyria-Danazol 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
Other Criteria	A. Patient has ONE of the following diagnoses: 1. Endometriosis amenable to hormonal management 2. Hereditary angioedema, B. For ENDOMETRIOSIS AMENABLE TO HORMONE MANAGEMENT: 1. Patient has a diagnosis of endometriosis confirmed by laparoscopy, OR If the diagnosis is not confirmed by surgery, then documentation of an adequate work-up and the clinical rationale for the diagnosis must be provided, AND 2. 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, C. For HEREDITARY ANGIOEDEMA: 1. Danazol will be used as prophylactic therapy for the prevention of hereditary angioedema attacks.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DEFERASIROX

Products Affected

- DEFERASIROX 125 MG TB FOR SUSP
- DEFERASIROX 250 MG TB FOR SUSP
- DEFERASIROX 500 MG TB FOR SUSP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: documentation of 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: documentation of 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: documentation of 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) Documentation of 2 lab values in the previous 3 months showing serum ferritin levels are consistently greater than 300mcg/L, OR (2) Documentation to confirm 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.
Other Criteria	INITIAL: (1) Patient has one of the following diagnoses: (1a) chronic iron overload due to blood transfusions OR (1b) chronic iron overload resulting from non-transfusion-dependent thalassemia (NTDT) syndromes
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DEFERIPRONE

Products Affected

- DEFERIPRONE 500 MG TABLET
- FERRIPROX 100 MG/ML SOLUTION
- FERRIPROX 500 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: Documentation of 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: Greater than or equal to 3 years of age and Less than or equal to 17 years of age.
Prescriber Restrictions	Prescribed by or given in consultation with a hematologist or hematologist/oncologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months
Other Criteria	Solution INITIAL: (1) Patient has a diagnosis of Iron overload, chronic-transfusion related due to thalassemia syndrome or related to sickle cell disease or other anemias, (2) Patient meets one of the following: (2a) Patient has an intolerance (intolerable toxicities or clinically significant adverse effects) or contradiction to AT LEAST ONE of the following: Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine), OR (2b) Patient has had a trial and therapeutic failure (inadequate response) to AT LEAST ONE of the following: Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine) AND Patient meets one of the following: (i) Documentation of 2 lab values in the previous 3 months showing serum ferritin levels are consistently above 1000mcg/L, OR (ii) Documentation of evidence of cardiac iron accumulation (i.e., cardiac T2star MRI less than 10 milliseconds, iron induced cardiomyopathy, fall in LVEF, arrhythmia indicating inadequate chelation). Tablets Initial: Patient has a diagnosis of Iron overload, chronic-transfusion related due to thalassemia syndrome or related to sickle cell disease or other anemias, (2) Patient meets one of the following: (2a) Patient has an intolerance (intolerable toxicities or clinically significant adverse effects) or contradiction to AT LEAST ONE of the following: Exjade (deferasirox),

PA Criteria	Criteria Details
	Jadenu (deferasirox), or Desferal (deferoxamine), OR (2b) Patient has had a trial and therapeutic failure (inadequate response) to AT LEAST ONE of the following: Exjade (deferasirox), Jadenu (deferasirox), or Desferal (deferoxamine). RENEWAL: (1) Patient has a diagnosis of Iron overload, chronic-transfusion related due to thalassemia syndrome or related to sickle cell disease or other anemias.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DELAFLOXACIN

Products Affected

- BAXDELA 450 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	ACUTE BACTERIAL SKIN OR SKIN STRUCTURE INFECTION (ABSSSI): Diagnosis of animal or human bite, necrotizing fasciitis, diabetic foot infection, decubitis ulcer formation, myonecrosis or ecthyma gangrenosum
Required Medical Information	ABSSSI: One of the following: 1) Prescribed by or in consultation with an Infectious Disease (ID specialist) OR 2) Antimicrobial susceptibility testing shows susceptibility to delafloxacin and resistance to one standard of care agent for ABSSSI OR 3) If susceptibility results are unavailable, trial of or contraindication to one of the following agents for ABSSSI: gram positive targeting antibiotic (e.g., linezolid, clindamycin, doxycycline, Bactrim, vancomycin), penicillin antibiotic (e.g., amoxicillin), fluoroquinolone antibiotic (e.g., levofloxacin, ciprofloxacin, moxifloxacin), or cephalosporin antibiotic (e.g., ceftriaxone, cephalexin, cefazolin) COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): One of the following: 1) Therapy is prescribed by or in consultation with an Infectious Disease (ID specialist) OR 2) Antimicrobial susceptibility testing shows susceptibility to delafloxacin and resistance to at least two standard of care agents for community-acquired bacterial pneumonia (CABP) OR 3) If susceptibility results are unavailable, trial of or contraindication to at least two standard of care agents for community-acquired bacterial pneumonia (CABP) (e.g., macrolide, doxycycline, alternative fluoroquinolone, beta-lactam, linezolid)
Age Restrictions	ABSSSI/CABP: 18 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	ABSSI / OTHER INDICATION: 14 days CABP: 10 days
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Any other indication prescribed by or in consultation with an Infectious Disease (ID) specialist.

DENOSUMAB

Products Affected

- PROLIA 60 MG/ML SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Hypocalcemia. Pregnancy.
Required Medical Information	OSTEOPOROSIS IN MEN AND WOMEN: Patient has a diagnosis of osteoporosis and have ONE of the following: (1) Documentation of 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) Documentation of T-score less than or equal to -1 or low bone mass and a history of fragility fracture to the hip or spine, (3) Documentation of 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 documentation of Hip DXA (femoral neck or total hip) or lumbar spine T-score less than or equal to -1, OR Patient has 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 or older
Prescriber Restrictions	None
Coverage Duration	12 months
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 ≥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

PA Criteria	Criteria Details
	(12) month trial with bisphosphonates (oral or IV) such as alendronate, risedronate, ibandronate, or zoledronic acid (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), OR Patient has a documented contraindication or intolerance to BOTH oral bisphosphonates AND intravenous (IV) bisphosphonates such as alendronate, risedronate, ibandronate, or zoledronic acid (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). GLUCOCORTICOID-INDUCED OSTEOPOROSIS: Patient will be initiating or is continuing systemic glucocorticoid therapy at a daily dosage equivalent 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 (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), OR Patient has a documented contraindication or intolerance to BOTH oral bisphosphonates AND intravenous (IV) bisphosphonates such as alendronate, risedronate, ibandronate, or zoledronic acid (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). TREATMENT OF BONE LOSS IN MEN WITH PROSTATE CANCER: Patient is receiving androgen deprivation therapy for non-metastatic prostate cancer. TREATMENT OF BONE LOSS IN WOMEN WITH BREAST CANCER: Patient is receiving adjuvant aromatase inhibitor therapy for breast cancer.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DESMOPRESSIN SOLUTION

Products Affected

- DESMOPRESSIN AC 4 MCG/ML VIAL INNER

PA Criteria	Criteria Details
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
Other Criteria	A. Patient has ONE of the following diagnoses: 1. Central cranial diabetes insipidus 2. Mild to moderate Von Willebrands disease 3. Hemophilia A. B. For central cranial diabetes insipidus: 1. 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. C. For mild to moderate Von Willebrands disease: 1. Patient has a diagnosis of mild to moderate classic von Willebrands disease (Type I) AND 2. Patient has factor VIII levels greater than 5% AND 3. 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. D. For hemophilia A: 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.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DIFENOXIN/ATROPINE

Products Affected

- MOTOFEN 1-0.025 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Patients with diarrhea associated with organisms that penetrate the intestinal mucosa (toxigenic E. coli, Salmonella species, Shigella) OR 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	A. Patient has a diagnosis of acute, nonspecific diarrhea OR is experiencing an acute exacerbation of chronic, functional diarrhea AND B. Motofen is being used as adjunctive treatment AND C. Patient has had a trial and therapeutic failure or intolerance to diphenoxylate/atropine (generic Lomotil).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DOCETAXEL

Products Affected

- DOCETAXEL 160 MG/16 ML VIAL MUV
- DOCETAXEL 160 MG/8 ML VIAL MUV
- DOCETAXEL 160 MG/8 ML VIAL SUV
- DOCETAXEL 20 MG/2 ML VIAL MDV
- DOCETAXEL 20 MG/2 ML VIAL SUV
- DOCETAXEL 80 MG/4 ML VIAL MDV, P/F
- DOCETAXEL 80 MG/4 ML VIAL SUV
- DOCETAXEL 80 MG/8 ML VIAL MDV, STERILE

PA Criteria	Criteria Details
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
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

PA Criteria	Criteria Details
	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).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DORNASE ALFA

Products Affected

- PULMOZYME 1 MG/ML AMPUL INNER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of cystic fibrosis (CF).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DOXEPIN CREAM

Products Affected

- DOXEPIN 5% CREAM

PA Criteria	Criteria Details
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
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 AND The request is for short term (up to 8 days) use.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DOXERCALCIFEROL

Products Affected

- DOXERCALCIFEROL 0.5 MCG CAP
- DOXERCALCIFEROL 1 MCG CAPSULE
- DOXERCALCIFEROL 2.5 MCG CAP

PA Criteria	Criteria Details
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 a diagnosis of secondary hyperparathyroidism associated with one of the following diagnoses: Stage 3 or 4 chronic kidney disease not yet requiring dialysis (pre-dialysis) AND Patient has had a clinical trial and failure, intolerance, or contraindication to calcitriol OR Stage 5 chronic kidney disease requiring dialysis AND Patient has a serum intact parathyroid hormone (iPTH) level greater than 10 pg/mL
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DUPILUMAB

Products Affected

- DUPIXENT 100 MG/0.67 ML SYRING INNER, SUV, P/F
- DUPIXENT 200 MG/1.14 ML PEN INNER, SUV, P/F
- DUPIXENT 200 MG/1.14 ML SYRING OUTER, SUV, P/F
- DUPIXENT 300 MG/2 ML PEN OUTER,SUV
- DUPIXENT 300 MG/2 ML SYRINGE OUTER, SUV, P/F

PA Criteria	Criteria Details
Exclusion Criteria	Atopic dermatitis: concurrent use with other systemic biologics or JAK inhibitors (e.g., Adbry, Rinvoq, Cibinqo). Asthma: Concurrent use with Xolair or an anti-IL5 biologic (e.g., Nucala, Cinqair, Fasenra).
Required Medical Information	ATOPIC DERMATITIS: INITIAL: Prescriber attests that patient has dermatitis involving 10% body surface area (BSA) involvement OR dermatitis affecting the face, head, neck, hands, feet, groin, or intertriginous areas. ASTHMA with an eosinophilic phenotype: INITIAL: (1) Documentation that the patient's peripheral blood eosinophil (EOS) count is between greater than or equal to 150 cells per microliter to less than or equal to 1500 cells per microliter within the past 12 months AND (2) Documentation confirming the patient's asthma is oral corticosteroid dependent. ATOPIC DERMATITIS: INITIAL: (1) Patient has documented diagnosis of moderate to severe atopic dermatitis AND (2) Must have tried (for at least 6 months) and failed ONE of the following, unless contraindicated: a. Topical corticosteroid b. Topical calcineurin inhibitor c. Topical PDE-4 inhibitor d. Topical JAK inhibitor e. Phototherapy, AND (3) Patient has TWO of the following: intractable pruritus, cracking and oozing/bleeding of affected skin, impaired activities of daily living. RENEWAL: (1) Patient has shown improvement while on therapy.
Age Restrictions	ASTHMA: 6 years of age or older. ATOPIC DERMATITIS: 6 months of age or older. RHINOSINUSITIS WITH NASAL POLYPS: 18 years of age or older. EOSINOPHILIC ESOPHAGITIS: Patient is 18 years of age or older, OR 12 to 17 years of age AND weighs at least 40kg. PRUIGO NODULARIS: 18 years of age or older
Prescriber Restrictions	Atopic dermatitis: Prescribed by, or in consultation with an allergist, immunologist, or dermatologist. Asthma: Prescribed by or in consultation with a physician specializing in pulmonary or allergy medicine. Rhinosinusitis: Prescribed by, or in consultation with an allergist, immunologist, or otolaryngologist. Eosinophilic Esophagitis: Prescribed by, or in consultation with a gastroenterologist, allergist, or immunologist

PA Criteria	Criteria Details
Coverage Duration	Chronic Rhinosinusitis/AD:6 mos. Asthma:12 mos. EE:6 mos. Pruigo Nodularis:12 mos. RENEW:12 mos.
Other Criteria	MODERATE TO SEVERE ASTHMA: INITIAL: (1) Patient has moderate to severe asthma with an eosinophilic phenotype (supported by documentation) or moderate to severe oral corticosteroid-dependent asthma (2) Patient is concurrently treated with medium, high-dose, or maximally tolerated ICS AND at least one other maintenance medication (e.g., LABA, long-acting muscarinic antagonist, a leukotriene receptor antagonist, theophylline), (3) Dupixent will NOT be used concurrently with Xolair or an anti-IL5 biologic when these are used for the treatment of asthma (4) Patient meets ONE of the following: i. Experienced at least ONE asthma exacerbation requiring systemic corticosteroid burst lasting at least 3 days within the past 12 months OR at least ONE serious exacerbation requiring hospitalization or emergency room visit within the past 12 months, OR ii. Poor symptom control despite current therapy as evidenced by at least THREE of the following within the past 4 weeks: a. Daytime asthma symptoms more than twice per week b. Any night waking due to asthma c. SABA reliever for symptoms more than twice per week d. Any activity limitation due to asthma. RENEWAL: 1. Patient will continue to use an ICS AND at least one other maintenance medication 2. Patient has shown a clinical response as evidenced by ONE of the following: a. Reduction in asthma exacerbation from baseline b. Decreased utilization of rescue medications c. Increase in percent predicted FEV1 from pretreatment baseline, OR d. Reduction in severity or frequency of asthma-related symptoms. CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP): INITIAL: (1) Patient has a documented diagnosis of CRSwNP with the presence of nasal polyps (by direct examination, endoscopy, or sinus CT scan) (2) Patient had a previous 90-day trial of ONE intranasal corticosteroid (3) Patient has inadequately controlled disease as determined by ONE of the following: a. Use of systemic steroids in the past 2 years, OR b. Endoscopic sinus surgery (4) Dupixent will be used as add-on maintenance treatment (i.e., in conjunction with maintenance intranasal steroids) RENEWAL: The patient has had clinical benefit compared to baseline. EOSINOPHILIC ESOPHAGITIS: (1) Patient diagnosis is confirmed by an esophagogastroduodenoscopy (EGD) with biopsy (2) Patient had a trial and failure or contraindication to dietary therapy (3) Patient had a trial and failure of or contraindication to a proton pump inhibitor (4) Patient had a trial and therapeutic failure of or contraindication to a topical glucocorticosteriod (e.g., fluticasone inhalation, swallowed budesonide, ciclesonide, mometasone) OR a systemic glucocorticosteroid (e.g., prednisone). RENEWAL: Patient has shown improvement while on therapy (e.g., symptom improvement or achieving histological remission

PA Criteria	Criteria Details
	defined as peak esophageal intraepithelial eosinophil count of less than or equal to 6 eos/hpf). PRUIGO NODULARIS: INITIAL: 1. Patient has documented diagnosis of pruigo nodularis.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ELBASVIR/GRAZOPREVIR

Products Affected

- ZEPATIER 50-100 MG TABLET OUTER

PA Criteria	Criteria Details
Exclusion Criteria	Patient has a limited life expectancy (less than 12 months) due to non-liver related comorbid conditions. Patient has moderate or severe hepatitis impairment (Child-Pugh B or C). Patient is currently taking any of the following medications: phenytoin, carbamazepine, rifampin, efavirenz (e.g., Atripla, Sustiva), atazanavir (e.g., Evotaz, Reyataz), darunavir (e.g., Prezcobix, Prezista), lopinavir, saquinavir, tipranavir, cyclosporine, nafcillin, ketoconazole, modafinil, bosentan, etravirine, elvitegravir/cobicistat/emtricitabine/tenofovir (e.g., Stribild, Genvoya), atorvastatin at doses higher than 20mg daily, or rosuvastatin at doses greater than 10mg daily, sofosbuvir (Sovaldi) (as a single agent), velpatasvir/sofosbuvir (Epclusa), ledipasvir/sofosbuvir (Harvoni), pibrentasvir/glecaprevir (Mavyret), or velpatasvir/sofosbuvir/voxilaprevir (Vosevi).
Required Medical Information	Patient has a recent HCV infection documented by one detectable HCV RNA level within the last 6 months (Note: Chart notes or lab reports required for documentation).
Age Restrictions	12 years of age or older OR weighs at least 30kg
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (e.g., a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model.
Coverage Duration	12- 16 weeks
Other Criteria	A. Patient has chronic hepatitis C OR has genotype 1 or genotype 4 hepatitis C, B. The patient meets ONE of the following criteria: has a contraindication to Epclusa AND Harvoni, OR has previously failed a short trial with Epclusa or Harvoni (e.g., inability to tolerate, adverse effect early in therapy) [NOTE: An individual who has completed a full course of therapy with Harvoni or Epclusa that did not achieve SVR will not be approved], C. Patients with genotype 1a infection require testing for baseline NS5A (nonstructural protein 5A) polymorphisms, D. Ribavirin use is required if the patient meets ANY of the following: 1) Patient has

PA Criteria	Criteria Details
	genotype 1a or 1b infection and was previously treated with HCV protease inhibitor triple therapy (HCV protease inhibitor (such as Victrelis, Incivek, Olysio) plus peginterferon/ribavirin, 2) Patient has genotype 1a infection, is treatment naive, and has baseline NS5A (nonstructural protein 5A) polymorphisms (variations of a type of protein), 3) Patient has genotype 1a infection, was previously treated, and has baseline NS5A (nonstructural protein 5A) polymorphisms (variations of a type of protein), 4) Patient has genotype 4 infection and was previously treated, E. Treatment experienced patients will be approved per product labeling (previous failure of peginterferon/ribavirin for genotype 1a, 1b or 4 and previous failure of HCV protease inhibitor triple therapy regimen for genotype 1a or 1b infection.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ELTROMBOPAG

Products Affected

- PROMACTA 12.5 MG TABLET
- PROMACTA 25 MG TABLET
- PROMACTA 50 MG TABLET
- PROMACTA 75 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA (cITP): A clinical response, as defined by an increase in platelet count to at least 50X109/L (at least 50,000 per microliter).
Age Restrictions	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA (cITP): 1 year of age or older. SEVERE APLASTIC ANEMIA: 2 years of age or older, AND Promacta will be used in combination with standard immunosuppressive therapy as first-line treatment
Prescriber Restrictions	cITP: Prescribed by or in consultation with a hematologist or immunologist.
Coverage Duration	INITIAL: cITP: 2 months. INITIAL/RENEWAL: 12 months.
Other Criteria	A. INITIAL: cITP: (1) Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (cITP), AND (2) Trial of or contraindication to corticosteroids or immunoglobulins, or an insufficient response to splenectomy. B. RENEWAL: cITP: (1) Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenia (cITP). C. THROMBOCYTOPENIA DUE TO CHRONIC HEPATITIS C: (1) Patient has a diagnosis of thrombocytopenia due to chronic hepatitis C, AND (2) Patients thrombocytopenia prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy. D. SEVERE APLASTIC ANEMIA: (1) Promacta will be used in combination with standard immunosuppressive therapy as first-line treatment (2 years and older), OR (2) Patient had an insufficient response to immunosuppressive therapy.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

EMVERM (MEBENDAZOLE)

Products Affected

- EMVERM 100 MG TABLET CHEW

PA Criteria	Criteria Details
Exclusion Criteria	Known hypersensitivity to mebendazole
Required Medical Information	Documentation (lab tests) confirming diagnosis
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	1 month
Other Criteria	1. Documentation (lab test) has confirmed infection. 2. If infection caused by enterobiasis, approve for qty of 1 tablet. 3. All other indications, approve for qty of 6 tablets.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ENDOTHELIN RECEPTOR ANTAGONISTS

Products Affected

- AMBRISENTAN 10 MG TABLET
- AMBRISENTAN 5 MG TABLET
- BOSENTAN 125 MG TABLET
- BOSENTAN 62.5 MG TABLET
- OPSUMIT 10 MG TABLET F/C,5X3

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): (1) Idiopathic pulmonary fibrosis (Ambrisentan, Letairis) (2) Concurrently taking cyclosporine A or glyburide (bosentan only).
Required Medical Information	INITIAL: PAH (WHO Group 1) (1) NYHA-WHO Functional Class II to IV symptoms AND (2) Documented confirmatory PAH diagnosis based on right heart catheterization
Age Restrictions	BOSENTAN: PULMONARY ARTERIAL HYPERTENSION: 3 years of age or older. LETAIRIS and OPSUMIT : PULMONARY ARTERIAL HYPERTENSION: 18 years of age or older.
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	12 months
Other Criteria	1. Patient has a diagnosis of pulmonary arterial hypertension (WHO Group 1). 2. RENEWAL: PAH: APPROVAL FOR BOSENTAN AND PATIENT IS 3 TO 17 YEARS OLD REQUIRES EITHER (2a) improvement in pulmonary vascular resistance, OR (2b) patient has remained stable or shown improvement in exercise ability (e.g., 6-minute walk test, World Health Organization [WHO] functional class symptoms). 3. APPROVAL FOR ALL OTHERS REQUIRES EITHER (3a) improvement from baseline in the 6-minute walk distance test, OR (3b) patient is stable from baseline in the 6-minute walk distance test AND WHO functional class has remained stable or has improved.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ERGOLOID MESYLATES ORAL

Products Affected

- ERGOLOID MESYLATES 1 MG TAB

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: Known hypersensitivity to ergoloid mesylates or in patients with known ergot alkaloid hypersensitivity, Ergoloid mesylate 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	A. INITIAL: 1. Documented diagnosis of Alzheimers disease, vascular dementia, or primary progressive dementia. 2. Patient intolerance to, or adequate trial of TWO of the following: galantamine, donepezil or rivastigmine. B. RENEWAL: 1. Documented diagnosis of Alzheimers disease, vascular dementia, or primary progressive dementia. 2. Documented positive clinical response to ergoloid therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ESLICARBAZEPINE

Products Affected

- APTIOM 200 MG TABLET
- APTIOM 400 MG TABLET
- APTIOM 600 MG TABLET
- APTIOM 800 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to eslicarbazepine acetate or oxcarbazepine.
Required Medical Information	N/A
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.).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ESTRAMUSTINE PHOSPHATE SODIUM

Products Affected

- EMCYT 140 MG CAPSULE

PA Criteria	Criteria Details
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 or 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ETHACRYNIC ACID

Products Affected

- ETHACRYNIC ACID 25 MG TABLET

PA Criteria	Criteria Details
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 or 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.
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A

EVEROLIMUS - ZORTRESS

Products Affected

- EVEROLIMUS 0.25 MG TABLET
- EVEROLIMUS 0.5 MG TABLET
- EVEROLIMUS 0.75 MG TABLET

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FIDAXOMICIN

Products Affected

- DIFICID 200 MG TABLET
- DIFICID 40 MG/ML SUSPENSION OUTER

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FILGRASTIM

Products Affected

- NIVESTYM 300 MCG/0.5 ML SYRING P/F, SUV, OUTER
- NIVESTYM 480 MCG/0.8 ML SYRING P/F, SUV, OUTER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FINGOLIMOD

Products Affected

- FINGOLIMOD 0.5 MG CAPSULE

PA Criteria	Criteria Details
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 OR (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 OR (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	N/A
Age Restrictions	10 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of a relapsing form of multiple sclerosis to include clinically isolated syndrome, relapsing-remitting disease and active secondary progressive disease.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FLUCYTOSINE

Products Affected

- FLUCYTOSINE 250 MG CAPSULE
- FLUCYTOSINE 500 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FLURANDRENOLIDE

Products Affected

- FLURANDRENOLIDE 0.05% CREAM
- FLURANDRENOLIDE 0.05% LOTION

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	A. Patient has a diagnosis of corticosteroid responsive dermatoses AND B. Patient 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, fluocinolone 0.025% cream and ointment, fluticasone 0.05% cream, hydrocortisone butyrate 0.1% ointment, mometasone 0.1% cream and ointment, and triamcinolone 0.1% cream, lotion, and ointment AND C. 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: 1. Medium to high potency: betamethasone dipropionate 0.05% cream and fluticasone 0.05% ointment AND 2. High potency: 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 AND 3. Ultra high potency: betamethasone dipropionate augmented 0.05% cream, clobetasol 0.05% solution, diflorasone 0.05% ointment
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FONDAPARINUX

Products Affected

- FONDAPARINUX 10 MG/0.8 ML SYR SDV,OUTER
- FONDAPARINUX 2.5 MG/0.5 ML SYR SDV, OUTER
- FONDAPARINUX 5 MG/0.4 ML SYR SDV, OUTER
- FONDAPARINUX 7.5 MG/0.6 ML SYR SDV, OUTER

PA Criteria	Criteria Details
Exclusion Criteria	ALL: 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.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Prophylaxis of Deep Vein Thrombosis: Fondaparinux will be used as prophylaxis of deep vein thrombosis (DVT) AND Patients body weight is 50 kg or more 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FORMOTEROL FUMARATE

Products Affected

- FORMOTEROL 20 MCG/2 ML NEB VL OUTER

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of asthma
Required Medical Information	None
Age Restrictions	18 years of age or 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GANCICLOVIR

Products Affected

- ZIRGAN 0.15% OPHTHALMIC GEL

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	2 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	Patient has a documented diagnosis of acute herpetic keratitis, AND Patient has a documented intolerance, contraindication, or treatment failure with adequate trials of BOTH trifluridine eye drops AND acyclovir oral tablets.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST (NSA)

Products Affected

- LEUPROLIDE 2WK 14 MG/2.8 ML KT MDV
- LUPRON DEPOT 11.25 MG 3MO KIT 3 MONTH, SUV
- LUPRON DEPOT 22.5 MG 3MO KIT SINGLE DOSE
- LUPRON DEPOT 3.75 MG KIT P/F, SUV
- LUPRON DEPOT 45 MG 6MO KIT
- LUPRON DEPOT 7.5 MG KIT SINGLE DOSE
- LUPRON DEPOT-4 MONTH KIT SINGLE DOSE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	ENDOMETRIOSIS: Prescribed by or in consultation with an obstetrician/gynecologist.
Coverage Duration	UL:3mos(3.75 mg) 1 fill(11.25 mg). GENDER DYSPHORIA/PROSTATE CANCER:12mos. ENDOMETRIOSIS:6mos
Other Criteria	INITIAL: A. ENDOMETRIOSIS: (1) Patient has a diagnosis of moderate to severe pain associated with endometriosis, AND(2) Patient had a previous 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), AND (3) Request is for Lupron Depot (3.75mg or 11.25mg). B. UTERINE LEIOMYOMATA: (1) Patient with anemia caused by uterine leiomyomata (fibroids), AND (2) Requested medication will be used concomitantly with iron therapy for the preoperative hematologic improvement, AND (3) Request is for Lupron Depot (3.75mg or 11.25mg). RENEWAL: A. ENDOMETRIOSIS: (1) Patient has a diagnosis of moderate to severe pain associated with endometriosis, AND (2) Patient has Improvement of pain related to endometriosis while on therapy, AND (3) Patient is receiving concomitant add-back therapy (i.e., combination estrogen-progestin or progestin-only contraceptive

PA Criteria	Criteria Details
	preparation), AND (4) Patient has NOT received a total course of therapy exceeding 12 months, AND (5) Request is for Lupron Depot (3.75mg or 11.25mg). INITIAL/RENEWAL: A. PROSTATE CANCER: (1) Patient has a diagnosis of advanced prostate cancer, AND (2) Request is for one of the following: (2a) Lupron Depot (7.5mg, 22.5mg, 30mg, 45mg), OR (2b) Camcevi. B. GENDER DYSPHORIA: (1) Request is for patient who is being treated for gender dysphoria, AND (2) Request is for one of the following: (2a) Lupron Depot 3.75mg (1 month kit), OR (2b) Lupron Depot 7.5mg (1 month kit), OR (2c) Lupron Depot 11.25mg (3 month kit).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	gender dysphoria

HEREDITARY ANGIOEDEMA (PA)

Products Affected

- ICATIBANT 30 MG/3 ML SYRINGE SUV, P/F,OUTER
- SAJAZIR 30 MG/3 ML SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: ICATIBANT, SAJAZIR: History of anaphylactic or life-threatening hypersensitivity reactions to icatibant or any component of the formulation. TAKHZYRO: History of anaphylactic or life-threatening hypersensitivity reactions to lanadelumab or any component of the formulation. Renewal (ICATIBANT, SAJAZIR): Concurrent use with alternative acute treatment for HAE attacks (e.g., Berinert, Kalbitor, Ruconest, icatibant). Renewal (TAKHZYRO): Concurrent use with alternative prophylactic treatment for HAE (e.g., Cinryze, Takhzyro, Haegarda, Orladeyo, danazol).
Required Medical Information	INITIAL: HAE ACUTE (ICATIBANT, Sajazir), 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) Documentation of 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) Documentation that the patient has a mutation in the C1-INH gene altering protein synthesis and/or function.
Age Restrictions	Takhzyro: 2 years and older Icatibant, Sajazir: 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
Other Criteria	INITIAL: HAE ACUTE (ICATIBANT, Sajazir): (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

PA Criteria	Criteria Details
	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 other agent being used for prophylaxis will be discontinued before starting the requested agent AND (b) 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 AND (4) Prescribed dosage follows Food and Drug Administration (FDA) label unless there is a documented clinical reasoning for higher dosage (Takhzyro: 300mg every 2 weeks). RENEWAL: HAE ACUTE (ICATIBANT, SAJAZIR): (1) Member has experienced a significant improvement in severity and duration of attacks yet continues to have occurrence of acute attacks AND (2) 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) Documentation of a 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 the patient is attack free for 6 months).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ILOPROST

Products Affected

- VENTAVIS 10 MCG/1 ML SOLUTION SINGLE-USE,P/F
- VENTAVIS 20 MCG/1 ML SOLUTION SNGLE-USE,P/F,INNER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	INITIAL: Documentation confirming patient's pulmonary arterial hypertension diagnosis based on right heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	12 months
Other Criteria	INITIAL: Patient has New York Heart Association-World Health Organization (NYHA-WHO) Functional Class III-IV symptoms, For WHO (World Health Organization) Functional Class III symptoms: ONE of the following: 1. The patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO of the following agents from different drug classes: a. Oral endothelin receptor antagonist (such as, ambrisentan, bosentan, or macitentan) b. Oral phosphodiesterase-5 inhibitor (such as, sildenafil or tadalafil) c. Oral cGMP inhibitor (such as, riociguat) 2. There is evidence of rapid progression or poor prognosis, For WHO Functional Class IV symptoms: Patient has had a trial and therapeutic failure, intolerance, or contraindication (harmful for) to at least ONE intravenous or subcutaneous prostacyclin (such as, epoprostenol or treprostinil). RENEWAL: ONE of the following: 1. Patient had improvement from baseline in the 6-minute walk distance test, OR 2. Patient has remained stable in the 6-minute walk distance test AND has a stable or improved World Health Organization (WHO) functional class.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IMMUNE GLOBULIN

Products Affected

- HYQVIA 10 GM-800 UNIT PACK
- HYQVIA 2.5 GM-200 UNIT PACK
- HYQVIA 20 GM-1,600 UNIT PACK
- HYQVIA 30 GM-2,400 UNIT PACK
- HYQVIA 5 GM-400 UNIT PACK

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Subcutaneous Use Only. Primary immunodeficiency disease only.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS - ADALIMUMAB PRODUCTS PRIOR AUTHORIZATION POLICY

Products Affected

- AMJEVITA(CF) 10 MG/0.2 ML SYRINGE 10 mg/0.2 mL
- AMJEVITA(CF) 20 MG/0.4 ML SYRINGE 20 mg/0.4 mL
- AMJEVITA(CF) 40 MG/0.8 ML AUTOINJECTOR INNER, SUV, P/F 40 mg/0.8 mL
- AMJEVITA(CF) 40 MG/0.8 ML SYRINGE 40 mg/0.8 mL
- HUMIRA 40 MG/0.8 ML SYRINGE P/F, SUV
- HUMIRA PEN 40 MG/0.8 ML P/F, SUV
- HUMIRA PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML
- HUMIRA PEN PSORIASIS-UVEITIS-ADOL HS STARTER 40 MG/0.8 ML
- HUMIRA(CF) 10 MG/0.1 ML SYRINGE
- HUMIRA(CF) 20 MG/0.2 ML SYRINGE
- HUMIRA(CF) 40 MG/0.4 ML SYRINGE
- HUMIRA(CF) PEDIATRIC CROHN'S START 80 MG/0.8 ML-40 MG/0.4 ML
- HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML SYRINGE
- HUMIRA(CF) PEN 40 MG/0.4 ML SUV, P/F
- HUMIRA(CF) PEN CROHN'S-UC-HS STARTER 80 MG/0.8 ML
- HUMIRA(CF) PEN PEDIATRIC ULCER COLITIS STARTER 80 MG/0.8 ML
- HUMIRA(CF) PEN PS-UV-ADOL HS START 80 MG/0.8 ML-40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (Note: This does NOT exclude the use of conventional synthetic DMARDs (e.g., methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) in combination with an adalimumab product), Polymyalgia Rheumatica (PMR)
Required Medical Information	Initial: CD: ONE of the following: 1. Patient tried or is taking corticosteroids, or it is contraindicated OR 2. Patient has tried one other conventional systemic therapy for Crohns disease such as azathioprine or methotrexate (exception: has already tried one biologic other than the requested medication) OR 3. Patient has enterocutaneous or rectovaginal fistulas OR 4. Patient had ileocolonic resection. JIA: ONE of the following: 1. Patient tried one other systemic therapy for this condition (Previous trial of one biologic other than the requested medication also counts) OR 2. Patient will start on adalimumab with methotrexate, sulfasalazine, or leflunomide OR 3. Patient has an absolute contraindication to methotrexate, sulfasalazine, or leflunomide OR 4. Patient has aggressive disease, as determined by the prescriber. HS: Patient tried at least ONE other therapy such as oral corticosteroids or systemic antibiotics. PsO:

PA Criteria	Criteria Details
	Patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant (exception: patient had a 3-month trial or intolerance to one biologic other than the requested medication) OR has a contraindication to methotrexate, as determined by the prescriber. RA: Patient tried ONE conventional synthetic DMARD (some examples include methotrexate, leflunomide) for at least 3 months (exception: patient had a 3-month trial of one biologic other than the requested medication). UC: Patient has tried one systemic therapy (Previous trial of one biologic other than the requested medication also counts), OR Patient has pouchitis AND Patient has tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema. Uveitis (including other posterior uveitides and panuveitis syndromes): Patient tried ONE of the following therapies: periocular, intraocular, or systemic corticosteroids, immunosuppressives (Previous trial of one biologic other than the requested medication also counts).
Age Restrictions	Plaque Psoriasis: 18 years of age or older. Crohn's disease: 6 years of age or older. Ulcerative colitis: 5 years of age or older.
Prescriber Restrictions	RA, JIA, AS, Spondyloarthritis, Other Subtypes: Prescribed by or in consultation w/rheumatologist. PsA: Prescribed by or in consult w/rheumatologist or derm. PsO, HS, PG: Prescribed or in consult w/derm. CD, UC: Prescribed or in consult w/GE. Uveitis, Scleritis or Sterile Corneal Ulceration: Prescribed or in consult w/ophthalmologist BD: Prescribed or in consult w/rheumatologist,derm,ophthalmologist,GE, or neurologist Sarcoidosis: Prescribed or in consult w/pulmonologist,ophthalmologist,or derm
Coverage Duration	INIT:HS,PlaquePsoriasis,BehcetsDisease,Sarcoidosis:3moPyodermaGangrenosum:4mo,Others:6mo.RENEW:12mo
Other Criteria	Behcets Disease: Patient tried at least ONE conventional therapy (A trial of one biologic other than the requested medication also counts) OR has ophthalmic manifestations of Behcets disease. Pyoderma Gangrenosum: Patient tried one systemic corticosteroid OR tried one other immunosuppressant for at least 2 months or was intolerant. Sarcoidosis: Patient tried at least one corticosteroid AND tried at least one immunosuppressive medication. Scleritis or Sterile Corneal Ulceration: Patient tried at least one other therapy condition. Spondyloarthritis, Other Subtypes (Note: Includes undifferentiated arthritis, non-radiographic axial spondyloarthritis, reactive arthritis (Reiters disease), or arthritis associated with inflammatory bowel disease): ONE of the following (a or b): a. Patient has arthritis in the knees, ankles, elbows, wrists, hands, and/or feet AND tried at least one conventional synthetic DMARD, OR b. Patient has

PA Criteria	Criteria Details
	axial spondyloarthritis AND has objective signs of inflammation, defined as C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory OR sacroiliitis reported on magnetic resonance imaging. Renewal: AS, JIA, PsA, RA: Patient on therapy for at least 6 months, AND experienced a beneficial clinical response from baseline via an objective measure prior to initiating an adalimumab product OR compared with baseline (prior to initiating an adalimumab product), patient experienced an improvement in at least one symptom, such as decreased pain, or improvement in function or activities of daily living. CD, UC: Patient on therapy for at least 6 months, AND experienced a beneficial clinical response from baseline via an objective measure (some examples include fecal markers, serum markers) OR compared with baseline patient experienced an improvement in at least one symptom, such as decreased pain, stool frequency. HS, PsO, Behcets Disease, Sarcoidosis: Patient on therapy for at least 90 days, AND experienced a beneficial clinical response from baseline via an objective measure AND compared with baseline patient experienced an improvement in at least one symptom. Uveitis (including other posterior uveitides and panuveitis syndromes): Patient on therapy for at least 6 months, AND experienced a beneficial clinical response from baseline via an objective measure OR compared with baseline (prior to initiating an adalimumab product) experienced an improvement in at least one symptom. Pyoderma Gangrenosum: Patient on therapy for at least 4 months, AND experienced a beneficial clinical response from baseline in at least one of the following: size, depth, or number of lesions AND compared with baseline experienced an improvement in at least one symptom. Scleritis or Sterile Corneal Ulceration, Spondyloarthritis, Other Subtypes: Patient on therapy for at least 6 months, AND experienced a beneficial clinical response from baseline OR compared with baseline patient experienced an improvement in at least one symptom.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Behcet's Disease, Pyoderma Gangrenosum, Sarcoidosis, Scleritis or Sterile Corneal Ulceration, Spondyloarthritis, Other Subtypes

INFLAMMATORY CONDITIONS - OTEZLA PRIOR AUTHORIZATION POLICY

Products Affected

- OTEZLA 28 DAY STARTER PACK
- OTEZLA 30 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Ankylosing Spondylitis, Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARD), Rheumatoid Arthritis
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Behcets disease: The medication is prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis: The medication is prescribed by or in consultation with a dermatologist. Psoriatic Arthritis: The medication is prescribed by or in consultation with a rheumatologist or a dermatologist.
Coverage Duration	Initial: 6 months. Renewal: 1 year
Other Criteria	Behcets Disease: A. Initial: Patient has oral ulcers or other mucocutaneous involvement AND Patient has tried at least ONE other systemic therapy, B. Renewal: Patient has been established on therapy for at least 4 months AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Otezla) AND Compared with baseline (prior to initiating Otezla), patient experienced an improvement in at least one symptom, such as decreased pain, or improved visual acuity (if ophthalmic manifestations). Plaque Psoriasis: A. Initial: Patient meets ONE of the following conditions (a or b): a) Patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant OR b) Patient has a contraindication to methotrexate, as determined by the prescriber, B. Renewal: Patient has been established on therapy for at least 4 months AND Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested drug) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by

PA Criteria	Criteria Details
	psoriasis AND Compared with baseline (prior to receiving the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning. Psoriatic Arthritis: A. Renewal: Patient has been established on the requested drug for at least 6 months AND Patient meets at least one of the following (a or b): a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Otezla) OR b) Compared with baseline (prior to initiating Otezla), patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue, improved function or activities of daily living, decreased soft tissue swelling in joints or tendon sheaths.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS - SKYRIZI INTRAVENOUS PRIOR AUTHORIZATION POLICY

Products Affected

- SKYRIZI 600 MG/10 ML VIAL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or with Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs).
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation, with a gastroenterologist.
Coverage Duration	Three doses for induction
Other Criteria	The medication will be used as induction therapy, AND Patient meets one of the following (i, ii, iii, or iv): i. Patient has tried or is currently taking a systemic corticosteroid, or a systemic corticosteroid is contraindicated in this patient, OR ii. Patient has tried one other conventional systemic therapy for Crohns disease (Note: Examples of conventional systemic therapy for Crohns disease include azathioprine, 6-mercaptopurine, or methotrexate. A previous trial of a biologic also counts as a trial of one other agent for Crohns disease.), OR iii. Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas, OR iv. Patient had ileocolonic resection (to reduce the chance of Crohns disease recurrence).
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS - SKYRIZI SUBCUTANEOUS PRIOR AUTHORIZATION POLICY

Products Affected

- SKYRIZI 150 MG/ML PEN
- SKYRIZI 150 MG/ML SYRINGE
- SKYRIZI 180 MG/1.2 ML ON-BODY OUTER, SUV, P/F
- SKYRIZI 360 MG/2.4 ML ON-BODY INNER, SUV, P/F

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or with Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs).
Required Medical Information	N/A
Age Restrictions	Plaque Psoriasis: 18 years of age or older.
Prescriber Restrictions	Crohns Disease: prescribed by or in consultation with a gastroenterologist. Plaque Psoriasis: prescribed by or in consultation with a dermatologist. Psoriatic Arthritis: prescribed by or in consultation with a rheumatologist or a dermatologist.
Coverage Duration	Crohns Disease, Psoriatic Arthritis: 6 mos/1yr Plaque Psoriasis: 3mos/1yr
Other Criteria	Initial: Crohns Disease. Patient meets ONE of the following conditions (a, b, c, or d): a) Patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated in this patient, OR b) Patient has tried one other conventional systemic therapy for Crohns disease, OR c) Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas, OR d) Patient had ileocolonic resection (to reduce the chance of Crohns disease recurrence), AND According to the prescriber, the patient will receive induction dosing with Skyrizi intravenous within 3 months of initiating therapy with Skyrizi subcutaneous. Plaque Psoriasis. Patient meets ONE of the following conditions (a or b): a) Patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant, OR Patient has a contraindication to methotrexate, as determined by the prescriber. Renewal: Crohns Disease: Patient has been established on therapy for at least 6 months, AND Patient meets at least one of the

PA Criteria	Criteria Details
	following (a or b): a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Skyrizi), OR Compared with baseline (prior to initiating Skyrizi), patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool. Plaque Psoriasis: Patient has been established on the requested drug for at least 90 days, AND Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating an the requested drug) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis, AND Compared with baseline (prior to receiving the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning. Psoriatic Arthritis: Patient has been established on therapy for at least 6 months, AND ii. Patient meets at least one of the following (a or b): a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Skyrizi), OR Compared with baseline (prior to initiating Skyrizi), patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue, improved function or activities of daily living, or decreased soft tissue swelling in joints or tendon sheaths.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY - ACTEMRA INTRAVENOUS

Products Affected

- ACTEMRA 80 MG/4 ML VIAL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD). 2. Crohns Disease 3. COVID-19 (Coronavirus Disease 2019)- Non-Hospitalized Patient.
Required Medical Information	Initial: CRS with CAR T-Cell Therapy: a patient who has been or will be treated with a chimeric antigen receptor (CAR) T-cell therapy. GCA: Patient has tried one systemic corticosteroid. PJIA: Patient has tried 1 other systemic therapy for this condition OR Patient will be starting on Actemra intravenous concurrently with methotrexate, sulfasalazine, or leflunomide OR Patient has an absolute contraindication to methotrexate, sulfasalazine, or leflunomide OR Patient has aggressive disease, as determined by the prescriber. RA: Patient has tried 1 conventional synthetic DMARD for at least 3 months. SJIA: Patient has tried 1 other systemic therapy for this condition. COVID-19: hospitalized adults who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO), Note: includes requests for cytokine release syndrome in a patient hospitalized with COVID-19. Inflammatory Arthritis Associated with Checkpoint Inhibitor Therapy: Patient is symptomatic despite a trial of at least 1 systemic corticosteroid AND Patient has tried at least 1 systemic nonsteroidal anti-inflammatory agent. Polymyalgia Rheumatica: Patient has tried 1 systemic corticosteroid. Stills Disease: Patient has tried 1 corticosteroid AND Patient has tried 1 conventional synthetic DMARD such as methotrexate given for at least 2 months or was intolerant to a conventional synthetic DMARD. Renewal: Inflammatory Arthritis Associated with Checkpoint Inhibitor Therapy: Patient has been on therapy for at least 6 months AND When assessed by at least 1 objective measure, patient had a beneficial clinical response from baseline (prior to initiating the requested drug) OR Compared with baseline (prior to initiating the requested drug), patient had an improvement in at least one symptom, such as less joint pain/tenderness, stiffness, or swelling. decreased fatigue. improved function or activities of daily living.
Age Restrictions	None

PA Criteria	Criteria Details
Prescriber Restrictions	GCA, PJIA, RA, SJIA, Polymyalgia Rheumatica, Stills Disease: prescribed by or in consultation with a rheumatologist. Castlemans Disease: prescribed by or in consultation with an oncologist or hematologist. Inflammatory Arthritis Associated with Checkpoint Inhibitor Therapy: prescribed by or in consultation with a rheumatologist or an oncologist.
Coverage Duration	CRS with CAR T-Cell Therapy, COVID19: 1 wk. All others: initial:6mos renewal:1yr
Other Criteria	GCA: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline , patient had an improvement in at least one symptom, such as decreased headache, scalp, or jaw pain. decreased fatigue, and/or improved vision. PJIA: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as improvement in limitation of motion, less joint pain or tenderness, decreased duration of morning stiffness or fatigue, improved function or activities of daily living. RA: Patient has been on therapy for at least 6 months AND Patient had a beneficial clinical response when assessed by at least one objective measure OR Patient had an improvement in at least one symptom, such as decreased joint pain, morning stiffness, or fatigue. improved function or activities of daily living. decreased soft tissue swelling in joints or tendon sheaths. SJIA: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient experienced an improvement in at least one symptom, such as less joint pain/tenderness, stiffness, or swelling. decreased fatigue. improved function or activities of daily living. Castlemans Disease: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as improvement or resolution of constitutional symptoms (e.g., fatigue, physical function). Polymyalgia Rheumatica: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as decreased shoulder, neck, upper arm, hip, or thigh pain or stiffness. improved range of motion AND/or decreased fatigue. Stills Disease: Patient has been on this medication for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from OR Compared with baseline, patient had an improvement in at least one symptom, such as less joint pain/tenderness,

PA Criteria	Criteria Details
	stiffness, or swelling. decreased fatigue. improved function or activities of daily living.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY - CIMZIA

Products Affected

- CIMZIA 200 MG VIAL KIT
- CIMZIA 2X200 MG/ML SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs).
Required Medical Information	Initial: CD: Patient meets 1 of the following: Patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated in this patient, OR Patient has tried other conventional systemic therapy for CD OR Patient has enterocutaneous or rectovaginal fistulas, OR Patient had ileocolonic resection. nr-axSpA: Patient has objective signs of inflammation, defined as at least one of the following: CRP elevated beyond the ULN for the reporting laboratory, OR Sacroiliitis reported on MRI. PsO: Patient meets ONE of the following conditions: Patient has tried at least 1 traditional systemic agent for psoriasis for at least 3 months, unless intolerant OR Patient has a contraindication to MTX, per the prescriber. RA: Patient has tried 1 conventional synthetic DMARD for at least 3 months OR patient already had a 3-month trial of at least one biologic other than the requested drug (Please Note: A biosimilar of the requested biologic does not count. Examples of biologic DMARDs are an etanercept product [for example, Enbrel, biosimilars], an adalimumab product [for example, Humira, biosimilars], an infliximab product [for example, Remicade, biosimilars], Simponi SC, Simponi Aria, Actemra [IV or SC], Kevzara, Kineret, Orencia [IV or SC], or a rituximab product [for example, Rituxan, biosimilars]). Spondyloarthritis, Other Subtypes: Patient has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet, AND Patient has tried at least 1 conventional synthetic DMARD. Renew: AS: Pt has been on therapy for at least 6 mos, AND Patient meets at least 1 of the following: When assessed by at least 1 objective measure, patient had a beneficial clinical response from baseline, OR Compared to baseline, patient had an improvement in at least 1 symptom or improvement in function or activities of daily living.
Age Restrictions	Crohns Disease, Plaque Psoriasis: 18 years of age or older.
Prescriber Restrictions	Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, Rheumatoid Arthritis, Spondyloarthritis, Other Subtypes: prescribed by, or

PA Criteria	Criteria Details
	in consultation with, a rheumatologist. Crohns Disease: prescribed by, or in consultation with, a gastroenterologist. Plaque Psoriasis: prescribed by, or in consultation with, a dermatologist. Psoriatic Arthritis: prescribed by, or in consultation with, a rheumatologist or a dermatologist.
Coverage Duration	Initial: Plaque Psoriasis: 3 months, all other indications: 6 months Renewal: 1 year
Other Criteria	Renew: CD: Patient has been on therapy for at least 6 mos, AND Patient meets at least 1 of the following: When assessed by at least 1 objective measure, patient had a beneficial clinical response from baseline, OR Compared to baseline, patient had an improvement in at least 1 symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool. nr-axSpA: Patient has been on therapy for at least 6 mos, AND Patient meets at least 1 of the following: When assessed by at least 1 objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient had an improvement in at least 1 symptom, or improvement in function/activities of daily living. PsO: Patient has been on therapy for at least 90 days, AND Patient had a beneficial clinical response, defined as improvement from baseline in at least 1 of the following: estimated BSA, erythema, induration/thickness, and/or scale of areas affected by psoriasis, AND Compared to baseline, patient had an improvement in at least 1 symptom, such as decreased pain, itching, and/or burning. PsA: Patient has been on therapy for at least 6 mos, AND Patient meets at least 1 of the following: When assessed by at least one objective measure, patient had a beneficial clinical response from baseline, OR Compared to baseline, patient had an improvement in at least 1 symptom. RA: Patient has been on therapy for at least 6 mos, AND Patient meets at least 1 of the following: Patient had a beneficial clinical response when assessed by at least 1 objective measure OR Patient had an improvement in at least 1 symptom. SpA, Other Subtypes: Patient has been on therapy for at least 6 mos, AND Patients meets at least one of the following: When assessed by at least one objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient had an improvement in at least one symptom.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Spondyloarthritis, Other Subtypes

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY - ETANERCEPT

Products Affected

- ENBREL 25 MG/0.5 ML SYRINGE INNER, P/F, SUV
- ENBREL 25 MG/0.5 ML VIAL OUTER, P/F, SUV
- ENBREL 50 MG/ML MINI CARTRIDGE INNER, P/F, SUV
- ENBREL 50 MG/ML SURECLICK INNER, P/F, SUV
- ENBREL 50 MG/ML SYRINGE INNER, P/F, SUV

PA Criteria	Criteria Details
Exclusion Criteria	1. Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD), 2. Crohns Disease, 3. Inflammatory Myopathies (Polymyositis, Dermatomyositis, Inclusion Body Myositis), 4. Hidradenitis Suppurativa, 5. Polymyalgia Rheumatica (PMR), 6. Sarcoidosis, 7. Large Vessel Vasculitis (e.g., Giant Cell Arteritis, Takayasus Arteritis, 8. Wegeners Granulomatosis
Required Medical Information	AS. Patient has been established on therapy for at least 6 months, Patient meets at least 1 of the following: When assessed by at least 1 objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient had an improvement in at least 1 symptom. JIA: Initial: Patient has tried 1 other systemic medication, OR Patient will be starting on therapy concurrently with methotrexate, sulfasalazine, or leflunomide, OR Patient has an absolute contraindication to methotrexate, sulfasalazine, or leflunomide, OR Patient has aggressive disease, per the prescriber OR Patient has been established on therapy for at least 6 months, AND Patient meets at least 1 of the following: When assessed by at least 1 objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient had an improvement in at least 1 symptom. PoS: Initial Therapy: Patient has tried at least 1 traditional systemic agent for psoriasis for at least 3 months, unless intolerant, OR Patient has a contraindication to methotrexate, as determined by the prescriber OR Patient has been on therapy for at least 90 days, AND Patient had a beneficial clinical response, defined as improvement from baseline in at least 1 of the following: estimated BSA, erythema, induration/thickness, and/or scale of areas affected by psoriasis, AND Compared with baseline, patient had an improvement in at least 1 symptom. PsA: Patient has been on therapy for at least 6 months, AND When assessed by at least 1 objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient had an improvement in at least 1 symptom. RA: Initial Therapy: Patient has

PA Criteria	Criteria Details
	tried 1 conventional synthetic DMARD for at least 3 months OR Patient has been on therapy for at least 6 months, AND Patient had a beneficial clinical response when assessed by at least 1 objective measure, OR Patient had an improvement in at least 1 symptom.
Age Restrictions	Initial: Plaque psoriasis: 4 years of age and older
Prescriber Restrictions	Initial: AS, JIA, RA, Spondyloarthritis, other subtypes, Stills Disease: Prescribed by or in consultation with a rheumatologist. PsO, Pyoderma Gangrenosum: Dermatologist. Psoriatic Arthritis: Rheumatologist or dermatologist. Behcets Disease: Rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist. Graft-Versus-Host Disease: Oncologist, hematologist, or a physician affiliated with a transplant center.
Coverage Duration	Initial:AS,JIA,PsA,RA,SpA,StillsDis:6mo PsO,Bechets:3mo GVHD:1mo PG:4mo. Renew:GVHD:3mo. Others:12mo
Other Criteria	Behcets Disease: Initia: Patient has tried at least 1 conventional therapy OR Patient has been on therapy for at least 90 days, AND When assessed by at least 1 objective measure, patient had a beneficial clinical response from baseline, AND Compared with baseline, patient had an improvement in at least 1 symptom. Graft-Vs-Host Disease: Initial: Patient has tried at least 1 conventional systemic treatment for graft-versus-host disease, Patient has been established on an etanercept product for at least 1 month, AND Patient meets at least 1 of the following: When assessed by at least one objective measure, patient had a beneficial clinical response from baseline, OR patient had an improvement in at least 1 symptom. Pyoderma Gangrenosum: Initial: Patient has tried one systemic corticosteroid OR one other immunosuppressant for at least 2 months or was intolerant to one of these medications, OR Patient has been on therapy for at least 4 months, AND Patient had a beneficial clinical response, Compared with baseline, patient had an improvement in at least 1 symptom. Spondyloarthritis, Other Subtypes: Initial: Patient has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet AND has tried at least 1 conventional synthetic DMARD has been tried, OR Patient has axial spondyloarthritis AND has objective signs of inflammation, defined as at least 1 of the following: CRP elevated beyond the ULN for the reporting laboratory, OR (2) Sacroiliitis reported on MR) OR Patient has been on therapy for at least 6 months, AND When assessed by at least 1 objective measure, patient had a beneficial clinical response from, OR Compared with baseline, patient had an improvement in at least one symptom. Stills Disease: Initial: Patient has tried one corticosteroid, AND Patient has tried one conventional synthetic DMARD given for at least 2 months or was intolerant, OR

PA Criteria	Criteria Details
	Patient has been on an this medication for at least 6 months, AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline, OR Compared with baseline, patient experienced an improvement in at least one symptom.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	1. Behcets Disease 2. Graft-Versus-Host Disease 3. Pyoderma Gangrenosum 4. Spondyloarthritis, Other Subtype 5. Stills Disease

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY - RINVOQ

Products Affected

- RINVOQ ER 15 MG TABLET
- RINVOQ ER 30 MG TABLET
- RINVOQ ER 45 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD). Concurrent use with an Anti-Interleukin Monoclonal Antibody. Concurrent use with Other Janus Kinase Inhibitors. Concurrent use with Xolair (omalizumab subcutaneous injection. Concurrent use with Other Potent Immunosuppressants. COVID-19 (Coronavirus Disease 2019).
Required Medical Information	Initial: AS: Patient has had a 3-month trial of at least ONE TNF-inhibitor, OR Patient has tried at least one TNF-inhibitor but was unable to tolerate a 3-month trial. Conventional synthetic DMARDs such as methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine do not count. AD: Patient has had a 3-month trial of at least ONE traditional systemic therapy, OR Patient has tried at least ONE traditional systemic therapy but was unable to tolerate a 3-month trial. PsA: Patient has had a 3-month trial of at least ONE TNF-inhibitor, OR Patient has tried at least one TNF-inhibitor but was unable to tolerate a 3-month trial. RA: Patient has had a 3-month trial of at least ONE TNF-inhibitor, OR Patient has tried at least one TNF-inhibitor but was unable to tolerate a 3-month trial. UC: Patient has had a 3-month trial of at least ONE TNF-inhibitor, OR Patient has tried at least one TNF-inhibitor but was unable to tolerate a 3-month trial. nr-axSpA: Patient meets BOTH of the following: i. Patient has objective signs of inflammation, defined as at least one of the following: a) CRP elevated beyond the ULN for the reporting laboratory OR b) Sacroiliitis reported on MRI AND ii. Patient meets ONE of the following: a) Patient has had a 3-month trial of at least ONE TNF-inhibitor OR b) Patient has tried at least one TNF-inhibitor but was unable to tolerate a 3-month trial (Note: Cimzia (certolizumab pegol SQ) is an example of TNF-inhibitor used for non-radiographic axial spondyloarthritis. Conventional synthetic DMARDs such as methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine do not count.)

PA Criteria	Criteria Details
Age Restrictions	Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis: 18 years of age or older. Atopic Dermatitis: 12 years of age or older
Prescriber Restrictions	Ankylosing Spondylitis, RA, nr-axSpA : prescribed by, or in consultation with, a rheumatologist. Psoriatic Arthritis: prescribed by, or in consultation with, a rheumatologist or a dermatologist. Ulcerative Colitis: prescribed by, or in consultation with, a gastroenterologist. Atopic Dermatitis: prescribed by, or in consultation with, an allergist, immunologist, or dermatologist.
Coverage Duration	Initial: AS, nr-axSpA, PsA, RA, UC: 6 months. Atopic Derm: 3 months Renewal: 1 year
Other Criteria	Renew: AS: Patient has been on therapy for at least 6 months, AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient experienced an improvement in at least one symptom such as decreased pain or stiffness, or improvement in function or activities of daily living. AD: Patient has been on therapy for at least at least 90 days, AND Patient had a beneficial clinical response, defined as improvement from baseline in at least one of the following: estimated body surface area affected, erythema, induration/papulation/edema, excoriations, lichenification, and/or a decreased requirement for other topical or systemic therapies for atopic dermatitis, AND Compared with baseline, patient had an improvement in at least one symptom. PsA: Patient has been established on therapy for at least 6 months, AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline, OR Compared with baseline, patient experienced an improvement in at least one symptom. improved function or activities of daily living. decreased soft tissue swelling in joints or tendon sheaths. RA: Patient has been on therapy for at least 6 months, AND Patient had a beneficial clinical response when assessed by at least one objective measure, OR Patient had an improvement in at least one symptom, improved function or activities of daily living, decreased soft tissue swelling in joints or tendon sheaths. UC: Patient has been on therapy for at least 6 months, AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient experienced an improvement in at least one symptom. nr-axSpA: Patient has been on the therapy for at least 6 months AND Patient meets at least one of the following: When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline OR Compared with baseline, patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY - SIMPONI SQ

Products Affected

- SIMPONI 100 MG/ML PEN INJECTOR
- SIMPONI 100 MG/ML SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	1. Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD). 2. Plaque Psoriasis without Psoriatic Arthritis.
Required Medical Information	Initial: RA: Patient has tried 1 conventional synthetic DMARD for at least 3 months. UC: Patient has tried 1 systemic therapy, OR Patient meets BOTH of the following: Patient has pouchitis, AND Patient has tried therapy with an antibiotic, probiotic, corticosteroid enema, or Rowasa (mesalamine) enema. Spondyloarthritis, Other Subtypes: Patient meets 1 of the following (a or b): a) Patient meets both of the following: Patient has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet, AND Patient has tried at least ONE conventional synthetic DMARD, OR b) Patient has axial spondyloarthritis AND has objective signs of inflammation, defined as at least one of the following: CRP elevated beyond the upper limit of normal for the reporting laboratory, OR Sacroiliitis reported on MRI. Renewal: AS: Patient has been on therapy for at least 6 months, AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient had an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living.
Age Restrictions	UC: 18 years of age or older.
Prescriber Restrictions	AS, RA, Spondyloarthritis: prescribed by or in consultation with a rheumatologist. PsA: prescribed by or in consultation with a rheumatologist or a dermatologist. UC: prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Initial: 6 Months, Renewal: 1 year
Other Criteria	PsA: Patient has been on therapy for at least 6 months, AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline, patient had an

PA Criteria	Criteria Details
	improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue, improved function or activities of daily living, decreased soft tissue swelling in joints or tendon sheaths. RA: Patient has been on therapy for at least 6 months, AND Patient had a beneficial clinical response when assessed by at least one objective measure OR Patient had an improvement in at least one symptom, such as decreased joint pain, morning stiffness, or fatigue, improved function or activities of daily living, decreased soft tissue swelling in joints or tendon sheaths. UC: Patient has been on therapy for at least 6 months, AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding. Spondyloarthritis, Other Subtypes: Patient has been on therapy for at least 6 months AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline OR Compared with baseline, patient had an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Spondyloarthritis, other subtypes.

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY - TREMFYA

Products Affected

- TREMFYA 100 MG/ML INJECTOR
- TREMFYA 100 MG/ML SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or with Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs). Note: This does NOT exclude the use of methotrexate (a traditional systemic agent used to treat psoriasis) in combination with Tremfya.
Required Medical Information	Patient has ONE of the following diagnoses: 1. Plaque psoriasis OR 2. Psoriatic arthritis. 1. Plaque Psoriasis. Patient meets ONE of the following (A or B): A) Initial Therapy. Patient meets ALL of the following (i, and ii): i. Patient meets ONE of the following conditions (a or b): a) Patient has tried at least ONE traditional systemic agent for psoriasis for at least 3 months, unless intolerant Note: Examples include methotrexate, cyclosporine, acitretin, or psoralen plus ultraviolet A light (PUVA). An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic (such as, Humira, Orencia, Actemra, etc.) other than the requested drug. A biosimilar of the requested biologic does not count. A patient who has already tried a biologic for psoriasis is not required to step back and try a traditional systemic agent for psoriasis OR b) Patient has a contraindication to methotrexate, as determined by the prescriber OR B) Patient is Currently Receiving Tremfya. Patient meets ALL of the following (i, ii, and iii): i. Patient has been established on the requested drug for at least 90 days, Note: A patient who has received less than 90 days of therapy or who is restarting therapy with the requested drug is reviewed under criterion A (Initial Therapy) AND ii. Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested drug) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis AND iii. Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning.
Age Restrictions	Initial: Plaque psoriasis: 18 years of age and older

PA Criteria	Criteria Details
Prescriber Restrictions	Initial: Plaque psoriasis: Requested agent is prescribed by or in consultation with a dermatologist. Psoriatic arthritis: Requested agent is prescribed by or in consultation with a rheumatologist or a dermatologist.
Coverage Duration	Initial: Plaque psoriasis: 3 months Psoriatic arthritis: 6 months Renewal: 12 months
Other Criteria	2. Psoriatic Arthritis. Patient meets ONE of the following (A or B): A) Initial Therapy requirements OR B) Patient is Currently Receiving Tremfya. Patient meets BOTH of the following (i and ii): i. Patient has been established on the requested drug for at least 6 months, Note: A patient who has received less than 6 months of therapy or who is restarting therapy with the requested drug is reviewed under criterion A (Initial Therapy) AND ii. Patient meets at least one of the following (a or b): a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug), Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate) OR b) Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue, improved function or activities of daily living, decreased soft tissue swelling in joints or tendon sheaths.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY - XELJANZ/XELJANZ XR

Products Affected

- XELJANZ 1 MG/ML SOLUTION OUTER
- XELJANZ 10 MG TABLET
- XELJANZ 5 MG TABLET
- XELJANZ XR 11 MG TABLET
- XELJANZ XR 22 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD). Concurrent use with Other Potent Immunosuppressants (e.g., azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil). COVID-19 (Coronavirus Disease 2019). Renal Transplantation.
Required Medical Information	Xeljanz/Xeljanz XR tablets: Initial: AS, RA, PsA, UC: Patient has had a 3-month trial of at least one TNF inhibitor, OR Patient has tried at least one TNF-inhibitor but was unable to tolerate a 3-month trial. Xeljanz tablets/oral solution: Initial: JIA: Patient has had a 3-month trial of at least one TNF-inhibitor, OR Patient has tried at least one TNF-inhibitor but was unable to tolerate a 3-month trial.
Age Restrictions	Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis : 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months Renewal: 1 year
Other Criteria	Xeljanz/Xeljanz XR tablets Renewal: AS: Patient has been on therapy for at least 6 months, AND When assessed by at least one objective measure, patient had a beneficial clinical response from baseline, OR Compared with baseline patient experienced an improvement in at least one symptom. JIA (Xeljanz tablets/oral solution): Patient has been on therapy for at least 6 months, AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline, OR Compared with baseline, patient experienced an improvement in at least one

PA Criteria	Criteria Details
	symptom. Psoriatic Arthritis: Patient has been on therapy for at least 6 months, AND medication will be used in combination with methotrexate or another conventional synthetic DMARD, unless contraindicated AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline, OR Compared with baseline, patient experienced an improvement in at least one symptom. RA: Patient has been on therapy for at least 6 months, AND Patient experienced a beneficial clinical response when assessed by at least one objective measure, OR Patient experienced an improvement in at least one symptom. UC: Patient has been on therapy for at least 6 months, AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline, OR Compared with baseline, patient experienced an improvement in at least one symptom.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY - STELARA SUBCUTANEOUS

Products Affected

- STELARA 45 MG/0.5 ML SYRINGE
- STELARA 45 MG/0.5 ML VIAL SDV, P/F
- STELARA 90 MG/ML SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Ankylosing Spondylitis, 2. Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD)
Required Medical Information	Initial: CD: Patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated in this patient OR Patient has tried one conventional systemic therapy for Crohns disease OR c) Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR d) Patient had ileocolonic resection (to reduce the chance of Crohns disease recurrence) AND Per the prescriber, the patient will receive a single induction dose with Stelara intravenous within 2 months of initiating therapy with Stelara subcutaneous. PsO: 45mg syringe/vial: Patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant, OR Patient has a contraindication to methotrexate as determined by the prescriber. Note: If the 90 mg syringe is requested, patient meets one of the following: patient weighs greater than 100 kg OR patient is currently receiving the 90 mg syringe OR patient has received standard dosing with the 45 mg syringe/vial for at least 3 months with inadequate efficacy. PsA: Note: If the 90 mg syringe is requested, patient meets one of the following: patient has moderate to severe plaque psoriasis AND weighs greater than 100 kg OR patient is currently receiving the 90 mg syringe OR patient has received standard dosing with the 45 mg syringe/vial for at least 3 months with inadequate efficacy. UC: Patient has had a trial of one systemic agent for ulcerative colitis, OR BOTH of the following [(1) and (2)]: (1) Patient has pourchitis AND (2) Patient has tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema AND Per the prescriber, the patient will receive a single induction dose with Stelara intravenous within 2 months of initiating therapy with Stelara subcutaneous
Age Restrictions	Plaque Psoriasis and Psoriatic Arthritis: 6 years of age or older

PA Criteria	Criteria Details
Prescriber Restrictions	CD: prescribed by or in consultation with a gastroenterologist, PsO: prescribed by or in consultation with a dermatologist, PsA: prescribed by or in consultation with a rheumatologist or a dermatologist, UC: prescribed by or in consultation with a gastroenterologist.
Coverage Duration	CD, PsA, UC: 6 months/1 year PsO: 3 mos/1 year
Other Criteria	Renewal: CD: Patient has been on the requested drug for at least 6 months AND Patient meets at least one of the following: When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug) OR Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool. PsO: Patient has been on the requested drug for at least 90 days AND Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating an the requested drug) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis AND Compared with baseline (prior to receiving the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning. PsA: Patient has been on the requested drug for at least 6 months AND Patient meets at least one of the following: When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug) OR Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue. improved function or activities of daily living. decreased soft tissue swelling in joints or tendon sheaths. UC: Patient has been on the requested drug for at least 6 months AND Patient meets at least one of the following: a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug) OR Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLAMMATORY CONDITIONS PRIOR AUTHORIZATION POLICY -TALTZ

Products Affected

- TALTZ 80 MG/ML AUTOINJECTOR (2-PACK)
- TALTZ 80 MG/ML AUTOINJECTOR (3-PACK)
- TALTZ 80 MG/ML AUTOINJECTOR P/F,SDV,OUTER
- TALTZ 80 MG/ML SYRINGE P/F,SUV,OUTER

PA Criteria	Criteria Details
Exclusion Criteria	1. Concurrent Use with other Biologics or with Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs) 2. Inflammatory Bowel Disease (i.e., Crohns disease, ulcerative colitis)
Required Medical Information	Initial: nr-axSpA: Patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory, OR Sacroiliitis reported on magnetic resonance imaging, PoS: Patient has tried at least at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant, OR Patient has a contraindication to methotrexate, as determined by the prescribing physician
Age Restrictions	PsO: Greater than or equal to 6 years of age
Prescriber Restrictions	AS: prescribed by or in consultation with a rheumatologist nr-axSpa: prescribed by or in consultation with a rheumatologist. PsO: prescribed by or in consultation with a dermatologist. PsA: prescribed by or in consultation with a rheumatologist or a dermatologist.
Coverage Duration	Initial: AS, nr-axSpa, PsA: 6months PsO: 3 months. Renewal: 1 year
Other Criteria	Renewal: AS: Patient has been established on therapy for at least 6 months, AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Taltz), OR Compared with baseline (prior to initiating Taltz), patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living. nr-axSpA: Patient has been established on therapy for at least 6 months, AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Taltz), OR Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain or stiffness,

PA Criteria	Criteria Details
	or improvement in function or activities of daily living. PsO: Patient has been established on therapy for at least 90 days, AND Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating Taltz) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis, AND Compared with baseline (prior to initiating Taltz), patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning. PsA: Patient has been established on therapy for at least 6 months, AND When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Taltz), Compared with baseline (prior to initiating Taltz), patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue, improved function or activities of daily living, decreased soft tissue swelling in joints or tendon sheaths.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INSULIN GLULISINE

Products Affected

- APIDRA 100 UNIT/ML VIAL
- APIDRA SOLOSTAR 100 UNIT/ML OUTER, SUV

PA Criteria	Criteria Details
Exclusion Criteria	Use during episodes of hypoglycemia.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE 100 MCG/0.5 ML VIAL P/F, OUTER, SUV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	CHRONIC GRANULOMATOUS DISEASE (CGD): Prescribed by or given in consultation with a hematologist, infectious disease specialist, or immunologist. SEVERE MALIGNANT OSTEOPETROSIS (SMO): Prescribed by or given in consultation with an endocrinologist
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months.
Other Criteria	RENEWAL:CGD, SMO: 1) Patient has demonstrated clinical benefit compared to baseline (e.g., reduction in frequency and severity of serious infections) 2) Patient has not received hematopoietic cell transplantation
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ISAVUCONAZONIUM

Products Affected

- CRESEMBA 186 MG CAPSULE OUTER

PA Criteria	Criteria Details
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 or older
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist
Coverage Duration	3 months
Other Criteria	A. Patient has ONE of the following diagnoses: 1. Invasive aspergillosis 2. Invasive mucormycosis AND B. Patient has had a trial and therapeutic failure, intolerance, or contraindication to therapy with amphotericin B, posaconazole, or voriconazole.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ISOTRETINOIN

Products Affected

- AMNESTEEM 10 MG CAPSULE OUTER
- AMNESTEEM 20 MG CAPSULE OUTER
- AMNESTEEM 40 MG CAPSULE OUTER
- CLARAVIS 10 MG CAPSULE OUTER
- CLARAVIS 20 MG CAPSULE OUTER
- CLARAVIS 30 MG CAPSULE OUTER
- CLARAVIS 40 MG CAPSULE OUTER
- ISOTRETINOIN 10 MG CAPSULE OUTER
- ISOTRETINOIN 20 MG CAPSULE OUTER
- ISOTRETINOIN 30 MG CAPSULE OUTER
- ISOTRETINOIN 40 MG CAPSULE OUTER
- ZENATANE 10 MG CAPSULE INNER
- ZENATANE 20 MG CAPSULE INNER
- ZENATANE 30 MG CAPSULE OUTER, 3X10
- ZENATANE 40 MG CAPSULE INNER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	INITIAL/RENEWAL: 12 years of age and older.
Prescriber Restrictions	N/A
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.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ITRACONAZOLE ORAL

Products Affected

- ITRACONAZOLE 10 MG/ML SOLUTION
- ITRACONAZOLE 100 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	1. Concomitant administration of itraconazole with drugs metabolized by CYP3A4: oral midazolam, pimozide, quinidine, dofetilide, triazolam, lovastatin, and simvastatin 2. Treatment of onychomycosis to pregnant patients or to women contemplating pregnancy 3. Patients who have shown hypersensitivity to itraconazole, 4. 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. Patient has a documented diagnosis of onychomycosis of the toenail or fingernail due to dermatophytes (tinea unguium).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Toe/Finger Onychomycosis: 12/5 weeks Histo/Blasto: 12 months Asper: 6 months Candidiasis: 2 months
Other Criteria	ORAL CAPSULES ONLY: Blastomycosis or histoplasmosis 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. Aspergillosis: That patient is intolerant of or refractory (disease did not respond to treatment) to amphotericin B therapy 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

PA Criteria	Criteria Details
	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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IVABRADINE

Products Affected

- CORLANOR 5 MG TABLET
- CORLANOR 7.5 MG TABLET

PA Criteria	Criteria Details
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
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. Patient is in sinus rhythm AND 3. Patient has symptoms despite maximal beta-blocker therapy OR has a 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 a diagnosis of symptomatic NYHA class II-IV heart failure due to dilated cardiomyopathy AND 2. Patient is in sinus rhythm. RENEWAL CRITERIA: 1. Patient continues to meet initial

PA Criteria	Criteria Details
	criteria AND 2. Patient has experienced disease stabilization or improvement with medication as determined by the prescriber.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LACTULOSE

Products Affected

- KRISTALOSE 10 GM PACKET 30'S
- KRISTALOSE 20 GM PACKET 30'S
- LACTULOSE 10 GM PACKET

PA Criteria	Criteria Details
Exclusion Criteria	Patients who require a low galactose diet.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LANREOTIDE

Products Affected

- LANREOTIDE 120 MG/0.5 ML SYRNG
- SOMATULINE DEPOT 120 MG/0.5 ML SUV
- SOMATULINE DEPOT 60 MG/0.2 ML SUV
- SOMATULINE DEPOT 90 MG/0.3 ML

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	INITIAL: ACROMEGALY: Prescriber must provide documentation of the following baseline laboratory results from the patient's medical record: 1) Elevated serum IGF-1 level for patient's age range and gender, and 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LEDIPASVIR/SOFOSBUVIR

Products Affected

- HARVONI 33.75-150 MG PELLET PK OUTER
- HARVONI 45-200 MG PELLET PACKT OUTER
- HARVONI 45-200 MG TABLET
- HARVONI 90-400 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	(1) Currently taking any of the following medications: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, rosuvastatin, simeprevir, (Sovaldi), elvitegravir/cobicistat/emtricitabine/tenofovir (Stribild), tipranavir/ritonavir, pibrentasvir/glecaprevir (Mavyret), velpatasvir/sofosbuvir (Epclusa), elbasvir/grazoprevir (Zepatier), or velpatasvir/sofosbuvir/voxilaprevir (Vosevi). (2) Limited life expectancy (less than 12 months) due to non-liver related comorbid conditions (e.g., physician attestation).
Required Medical Information	Patient has a recent HCV infection documented by one detectable HCV RNA level within the last 6 months (Note: Chart notes or lab reports required for documentation).
Age Restrictions	3 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (for example, a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model
Coverage Duration	ledipasvir/sofosbuvir
Other Criteria	Patient has a diagnosis of chronic hepatitis C with genotype 1, genotype 4, genotype 5, OR genotype 6 and meets any of the following: (1) Treatment-experienced patients with no cirrhosis and genotype 1, previous treatment should include ONE of the following: a) peginterferon and ribavirin, b) triple therapy with HCV protease inhibitor, peginterferon and ribavirin, OR c) a prior non-NS5A inhibitor, sofosbuvir-containing regimen (2) For patients who are treatment-experienced with compensated cirrhosis and genotype 1, previous treatment should include either a) peginterferon and ribavirin, OR b) triple therapy with HCV protease inhibitor, peginterferon and ribavirin. (3) Patients who have decompensated cirrhosis or are post-

PA Criteria	Criteria Details
	liver transplant (without cirrhosis or with compensated cirrhosis), approval also requires that the requested medication will be used with ribavirin. (4) Requests for Harvoni 45mg/200mg pellets require that the patient is unable to swallow tablets.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LODOXAMIDE

Products Affected

- ALOMIDE 0.1% EYE DROP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Patient has a diagnosis of vernal keratoconjunctivitis, vernal conjunctivitis, and/or vernal keratitis AND Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO of the following: azelastine ophthalmic solution, cromolyn sodium, ophthalmic solution, epinastine ophthalmic solution.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LOMUSTINE

Products Affected

- GLEOSTINE 10 MG CAPSULE
- GLEOSTINE 100 MG CAPSULE
- GLEOSTINE 40 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The requested medication will be used in combination with other chemotherapies
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LUMACAFTOR-IVACAFTOR

Products Affected

- ORKAMBI 100 MG-125 MG TABLET
- ORKAMBI 100-125 MG GRANULE PKT
- ORKAMBI 150-188 MG GRANULE PKT
- ORKAMBI 200 MG-125 MG TABLET
- ORKAMBI 75-94 MG GRANULE PKT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	INITIAL: Documentation that the patient is homozygous for the F508del-CFTR gene mutation
Age Restrictions	1 year of age or older
Prescriber Restrictions	Initial: Prescribed by or in consultation with a pulmonologist or CF expert
Coverage Duration	INITIAL: 24 weeks. 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), OR (b) Patient has improved, maintained, or demonstrated less than expected decline in BMI (body mass index), OR (c) Reduction in rate of pulmonary exacerbations.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LURASIDONE

Products Affected

- LURASIDONE HCL 120 MG TABLET
- LURASIDONE HCL 20 MG TABLET
- LURASIDONE HCL 40 MG TABLET
- LURASIDONE HCL 60 MG TABLET
- LURASIDONE HCL 80 MG TABLET

PA Criteria	Criteria Details
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	N/A
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 Documentation of trial and therapeutic failure, intolerance, or contraindication to at least THREE (3) of the following: risperidone, quetiapine, olanzapine, ziprasidone, aripiprazole. (Note: Chart notes, medical records, or electronic claim history required for documentation).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MECASERMIN

Products Affected

- INCRELEX 40 MG/4 ML VIAL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
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
Other Criteria	INITIAL: Diagnoses of : 1. Severe primary insulin growth-like factor 1 deficiency (IGF-1: hormone levels that promote normal bone and tissue growth and development are extremely low or undetectable in the blood) [severe Primary IGF-1 deficiency (IGFD) is defined by: height standard deviation score less than or equal to -3.0, basal IGF-1 (insulin growth-like factor 1) standard deviation score less than or equal to -3.0, and normal or elevated growth hormone [serum growth hormone level of greater than or equal to 10ngm/mL to at least 2 stimuli (insulin, levodopa, arginine, clonidine or glucagon)] 2. Growth hormone gene deletion (not growth hormone-deficient short stature) and developed neutralizing antibodies to growth hormone, AND Documentation of patients bone growth plates (epiphyses) are open as confirmed by radiograph of the wrist and hand. RENEWAL: Patient has shown a response in the first 6 months of insulin wth-like factor-1 (IGF-1) therapy (for example, increase in height, increase in height velocity, etc.).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MELPHALAN

Products Affected

- MELPHALAN 2 MG TABLET

PA Criteria	Criteria Details
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: Documentation of patients diagnosis of multiple myeloma OR non-resectable epithelial carcinoma of the ovary AND melphalan is being used for palliative treatment. INTRAVENOUS INJECTION: Documentation of patients diagnosis of multiple myeloma AND melphalan is being used for palliative treatment AND oral melphalan therapy is not appropriate (dysphagia, difficulty swallowing, etc.).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MEMANTINE ORAL SOLUTION

Products Affected

- MEMANTINE HCL 2 MG/ML SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Known hypersensitivity to memantine hydrochloride
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	A. Patient has a diagnosis of moderate to severe dementia of the Alzheimers type. B. Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic memantine tablets AND C. Patient is unable to ingest solid oral dosage forms due to one of the following: (1) Oral/motor difficulties OR (2) Dysphagia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MESALAMINE

Products Affected

- MESALAMINE 1,000 MG SUPP

PA Criteria	Criteria Details
Exclusion Criteria	Patients with known or suspected hypersensitivity to salicylates or aminosalicylates
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	A. Patient has a diagnosis of mild to moderate active ulcerative proctitis. B. Patient has had a trial and failure, intolerance, or contraindication to all of the following: Mesalamine 1.2gm DR, Mesalamine 800mg DR, and Mesalamine 4gm Enema.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MESNA

Products Affected

- MESNEX 400 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a Hematologist or Oncologist
Coverage Duration	12 months
Other Criteria	The request is for the prophylaxis of ifosfamide-induced hemorrhagic cystitis.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

METAXALONE

Products Affected

- METAXALONE 400 MG TABLET
- METAXALONE 800 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Known tendency to drug induced, hemolytic, or other anemias. Significantly impaired renal or hepatic function.
Required Medical Information	N/A
Age Restrictions	12 years of age and older.
Prescriber Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

METHOXSALEN

Products Affected

- METHOXSALEN 10 MG SOFTGEL

PA Criteria	Criteria Details
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 or older
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist
Coverage Duration	12 months
Other Criteria	A. Patient has a diagnosis of severe, recalcitrant, disabling psoriasis AND B. Patients diagnosis is documented by biopsy AND C. Patients disease is not adequately responsive to other forms of therapy AND D. Methoxsalen will be used in conjunction with a schedule of controlled doses of long wave ultraviolet radiation. (Note: Chart notes required for documentation.)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MIGRAINE - CALCITONIN GENE-RELATED PEPTIDE INHIBITORS - EMGALITY PRIOR AUTHORIZATION POLICY

Products Affected

- EMGALITY 120 MG/ML PEN P/F, SUV, OUTER
- EMGALITY 120 MG/ML SYRINGE P/F, SUV, OUTER
- EMGALITY 300 MG DOSE (100 MG/ML X 3 SYRINGES) P/F, SUV, OUTER

PA Criteria	Criteria Details
Exclusion Criteria	(1) Treatment of acute migraine. (2) Concurrent use with another calcitonin gene-related peptide (CGRP) inhibitor being prescribed for migraine headache prevention [Examples include: Aimovig (erenumab-aooe subcutaneous injection), Ajovy (fremanezumab-vfrm subcutaneous injection), Vyepti (eptinezumab-jjmr intravenous infusion), and Qulipta (atogepant tablets)]. (3) Concurrent use with Nurtec ODT (rimegepant sulfate orally disintegrating tablet) when used as a preventive treatment of migraine.
Required Medical Information	Treatment of episodic cluster headache: INITIAL: Patient must meet ALL of the following: Patient has between one headache every other day and eight headaches per day, AND Patient has tried at least one standard prophylactic pharmacologic therapy for cluster headache, AND Patient has had inadequate efficacy or has experienced adverse event(s) severe enough to warrant discontinuation of the standard prophylactic pharmacologic therapy, according to the prescriber. Migraine headache prevention: INITIAL: Patient must meet all of the following: Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND Patient has tried at least two standard prophylactic pharmacologic therapies, each from a different pharmacologic class [Note: Examples of standard prophylactic (preventive) pharmacologic therapies for migraine include angiotensin receptor blocker, angiotensin converting enzyme inhibitor, anticonvulsant, beta-blocker, calcium channel blocker, tricyclic antidepressant, other antidepressant. Of note, standard prophylactic (preventive) pharmacologic therapies do not include oral or injectable CGRP inhibitors], AND Patient meets ONE of the following criteria: Patient has had inadequate efficacy to both of those standard prophylactic pharmacologic therapies, according to the prescriber, OR Patient has experienced adverse event(s) severe enough to warrant discontinuation of both of those standard prophylactic pharmacologic therapies, according to the prescriber, OR Patient meets BOTH of the

PA Criteria	Criteria Details
	following: Patient has had inadequate efficacy to one standard prophylactic pharmacologic therapy, AND Patient has experienced adverse event(s) severe enough to warrant discontinuation to another standard prophylactic pharmacologic therapy, according to the prescriber.
Age Restrictions	18 years of age and older
Prescriber Restrictions	NA
Coverage Duration	Treatment of episodic cluster headache treatment: 6 months. Migraine headache prevention: 12 months
Other Criteria	Migraine headache prevention: CONTINUATION - Patient is currently taking Emgality and has had a significant clinical benefit from the medication as determined by the prescriber. (Note: Examples of significant clinical benefit include a reduction in the overall number of migraine days per month or a reduction in number of severe migraine days per month from the time that Emgality was initiated.)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MIGRAINE - CALCITONIN GENE-RELATED PEPTIDE INHIBITORS - AJOVY CARE VALUE POLICY

Products Affected

- AIMOVIG 140 MG/ML AUTOINJECTOR
- AIMOVIG 70 MG/ML AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Acute Treatment of Migraine. Cluster Headache, Treatment or Prevention. Concurrent use with another calcitonin gene-related peptide (CGRP) inhibitor being prescribed for migraine headache prevention. Concurrent use with Nurtec ODT (rimegepant sulfate orally disintegrating tablet) when used as a preventive treatment of migraine
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	A. Patient has a diagnosis/indication for migraine headache prevention AND B. Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventive medication) AND C. Patient has tried at least two standard prophylactic pharmacologic therapies, each from a different pharmacologic class (Note: Examples of standard prophylactic pharmacologic therapies include angiotensin receptor blocker, angiotensin converting enzyme inhibitor, anticonvulsant, β-blocker, calcium channel blocker, tricyclic antidepressant, other antidepressant. Of note, "standard prophylactic (preventive) pharmacologic therapies" do not include oral or injectable CGRP inhibitors.) AND D. Patient meets ONE of the following criteria (i, ii, or iii): i. Patient has had inadequate efficacy to both of those standard prophylactic pharmacologic therapies, according to the prescriber OR ii. Patient has experienced adverse event(s) severe enough to warrant discontinuation of both of those standard prophylactic pharmacologic therapies, according to the prescriber

PA Criteria	Criteria Details
	OR iii. Patient meets BOTH of the following (a and b): a) Patient has had inadequate efficacy to one standard prophylactic pharmacologic therapy AND b) Patient has experienced adverse event(s) severe enough to warrant discontinuation to another standard prophylactic pharmacologic therapy, according to the prescriber AND E. If the patient is currently taking Ajovy, the patient has had a significant clinical benefit from the medication as determined by the prescriber. (Note: Examples of significant clinical benefit include a reduction in the overall number of migraine days per month or a reduction in number of severe migraine days per month from the time that Ajovy was initiated.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MIGRAINE - NURTEC ODT CARE VALUE POLICY

Products Affected

- NURTEC ODT 75 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another calcitonin gene-related peptide (CGRP) inhibitor being prescribed for migraine headache prevention if Nurtec ODT is being taken for the preventive treatment of episodic migraine.
Required Medical Information	N/A
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Migraine, Acute Treatment: Patient meets ONE of the following: Patient has tried at least one triptan therapy OR Patient has a contraindication to triptan(s) according to the prescriber. (Note: Examples of contraindications to triptans include a history of coronary artery disease. cardiac accessory conduction pathway disorders. history of stroke, transient ischemic attack, or hemiplegic or basilar migraine. peripheral vascular disease. ischemic bowel disease. uncontrolled hypertension OR severe hepatic impairment.) Preventive Treatment of Episodic Migraine: Patient meets the following criteria (A, B, C, and D): (A) Patient has ≥ 4 and less than 15 migraine headache days per month (prior to initiating a migraine-preventive medication) AND (B) Patient has tried at least two standard prophylactic (preventive) pharmacologic therapies, each from a different pharmacologic class (Note: Examples of standard prophylactic (preventive) pharmacologic therapies include angiotensin receptor blocker, anticonvulsant, beta-blocker, tricyclic antidepressant, other antidepressant) AND (C) Patient meets ONE of the following criteria (i, ii, or iii): (i) Patient has had inadequate efficacy to both of those standard prophylactic (preventive) pharmacologic therapies, according to the prescriber OR (ii) Patient has experienced adverse event(s) severe enough to warrant discontinuation of both of those standard prophylactic (preventive) pharmacologic therapies,

PA Criteria	Criteria Details
	according to the prescriber OR (iii) Patient has had inadequate efficacy to one standard prophylactic (preventive) pharmacologic therapy and has experienced adverse event(s) severe enough to warrant discontinuation of another standard prophylactic (preventive) pharmacologic therapy, according to the prescriber AND (D) If the patient is currently taking Nurtec ODT, patient has had a significant clinical benefit from the medication as determined by the prescriber. (Note: Examples of significant clinical benefit include a reduction in the overall number of migraine days per month or a reduction in number of severe migraine days per month from the time that Nurtec ODT was initiated).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MIGRAINE - REYVOW/UBRELVY CARE VALUE POLICY

Products Affected

- REYVOW 100 MG TABLET
- REYVOW 50 MG TABLET
- UBRELVY 100 MG TABLET OUTER
- UBRELVY 50 MG TABLET OUTER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	MIGRAINE, ACUTE TREATMENT: Patient meets ONE of the following: (1) Patient has tried at least one triptan therapy OR (2) Patient has a contraindication to triptan(s) according to the prescriber (Note: Examples of contraindications to triptans include a history of coronary artery disease. cardiac accessory conduction pathway disorders. history of stroke, transient ischemic attack, or hemiplegic or basilar migraine. peripheral vascular disease. ischemic bowel disease. uncontrolled hypertension OR severe hepatic impairment).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MILNACIPRAN

Products Affected

- SAVELLA 100 MG TABLET
- SAVELLA 12.5 MG TABLET
- SAVELLA 25 MG TABLET
- SAVELLA 50 MG TABLET
- SAVELLA TITRATION PACK

PA Criteria	Criteria Details
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	A. 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, psychiatrist, neurologist, or pain management specialist.
Coverage Duration	12 months
Other Criteria	A. Symptoms have been present for at least 3 months, AND B. Other conditions mistaken for fibromyalgia have been ruled out (e.g., rheumatoid arthritis, peripheral neuropathies, infection), AND C. Patient has had a trial and failure, intolerance, or contraindication to a tricyclic antidepressant (i.e., amitriptyline) AND duloxetine.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MILTEFOSINE

Products Affected

- IMPAVIDO 50 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient weighs at least 30kg or more. Documentation is provided for the identification of Leishmaniasis species via ONE of the following CDC recommended tests: (1) Stained slides (using tissue from biopsy specimens, impression smears or dermal scrapings OR (2) Culture medium OR (3) Polymerase chain reaction (PCR) OR (4) Serologic testing (e.g. rK39 Rapid Test).
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MIRABEGRON

Products Affected

- MYRBETRIQ ER 25 MG TABLET F/C
- MYRBETRIQ ER 50 MG TABLET F/C

PA Criteria	Criteria Details
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	12 months
Other Criteria	INITIAL: 1. Diagnosis of overactive bladder, neurogenic detrusor over activity 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. Quantity limit: 1 tablet per day.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MITOTANE

Products Affected

- LYSODREN 500 MG TABLET

PA Criteria	Criteria Details
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	Patient has a diagnosis of inoperable, functional or nonfunctional adrenal cortical carcinoma
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MODAFINIL

Products Affected

- MODAFINIL 100 MG TABLET
- MODAFINIL 200 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to modafinil or armodafinil.
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 documented diagnosis of narcolepsy supported by a sleep study 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 documentation of current work schedule is provided showing that patient is working a minimum of five (or more) overnight shifts per month 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 documented diagnosis of obstructive sleep apnea is supported by a sleep study 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

07.01.2023

MS AGENTS (AVONEX, PLEGRIDY, COPAXONE, GLATOPA) - PRIOR AUTHORIZATION POLICY

Products Affected

- AVONEX PEN 30 MCG/0.5 ML KIT OUTER, SUV, P/F
- AVONEX PREFILLED SYR 30 MCG KIT OUTER, SUV, P/F
- BETASERON 0.3 MG KIT OUTER, SUV, P/F
- GLATIRAMER 20 MG/ML SYRINGE OUTER,SUV
- GLATIRAMER 40 MG/ML SYRINGE INNER,SDV
- GLATOPA 20 MG/ML SYRINGE OUTER, SUV
- GLATOPA 40 MG/ML SYRINGE OUTER,SUV
- PLEGRIDY 125 MCG/0.5 ML PEN P/F,OUTER,SDV
- PLEGRIDY 125 MCG/0.5 ML SYRING OUTER, SUV, P/F
- PLEGRIDY PEN INJ STARTER PACK
- PLEGRIDY SYRINGE STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with Other Disease-Modifying Agents Used for Multiple Sclerosis. Non-Relapsing Forms of Multiple Sclerosis.
Required Medical Information	Renewal: Patient is Currently Receiving this medication for greater than or equal to 1 Year AND Patient meets one of the following: (1) Patient experienced a beneficial clinical response when assessed by at least one objective measure. Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions]. stabilization or reduced worsening on the Expanded Disability State Scale (EDSS) score. achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4. improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale. reduction or absence of relapses. improvement or maintenance on the six-minute walk test or 12-Item MS Walking Scale. improvement on the Multiple Sclerosis Functional Composite (MSFC) score AND/or attenuation of brain volume loss OR (2) Patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.
Coverage Duration	1 year
Other Criteria	Avonex, Plegridy, Copaxone & Glatopa: Patient has a relapsing form of multiple sclerosis (for example: clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MULTIPLE SCLEROSIS PRIOR AUTHORIZATION POLICY - AUBAGIO

Products Affected

- AUBAGIO 14 MG TABLET
- AUBAGIO 7 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	(1) Concurrent use with other Disease-Modifying Agents Used for Multiple Sclerosis. (2) Non-relapsing forms of Multiple Sclerosis.
Required Medical Information	RENEWAL: A. Patient is currently receiving Aubagio for greater than or equal to 1 year AND B. Patient has a relapsing form of multiple sclerosis (Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease) AND C. Patient meets one of the following: (1) Patient experienced a beneficial clinical response when assessed by at least one objective measure (Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions], stabilization or reduced worsening on the Expanded Disability State Scale (EDSS) score, achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4, improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale, reduction or absence of relapses, improvement or maintenance on the six-minute walk test or 12-Item MS Walking Scale, improvement on the Multiple Sclerosis Functional Composite (MSFC) score AND/or attenuation of brain volume loss) OR (2) Patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.
Coverage Duration	1 year
Other Criteria	Initial: Patient has a relapsing form of multiple sclerosis (Note: Examples of relapsing forms of multiple sclerosis include clinically isolated

PA Criteria	Criteria Details
	syndrome, relapsing remitting disease, and active secondary progressive disease).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MULTIPLE SCLEROSIS PRIOR AUTHORIZATION POLICY - DIMETHYL FUMARATE

Products Affected

- DIMETHYL FUMARATE 30D START PK
- DIMETHYL FUMARATE DR 120 MG CP
- DIMETHYL FUMARATE DR 240 MG CP

PA Criteria	Criteria Details
Exclusion Criteria	(1) Concurrent Use with Other Disease-Modifying Agents Used for Multiple Sclerosis. (2) Non-relapsing forms of Multiple Sclerosis.
Required Medical Information	RENEWAL: Patient Has Been Receiving Dimethyl Fumarate for 1 Year, AND Patient has a relapsing form of multiple sclerosis, AND Patient experienced a beneficial clinical response when assessed by at least one objective measure. Note: Examples include stabilization or reduced worsening in disease activity as evaluated by magnetic resonance imaging (MRI) [absence or a decrease in gadolinium enhancing lesions, decrease in the number of new or enlarging T2 lesions], stabilization or reduced worsening on the Expanded Disability State Scale (EDSS) score, achievement in criteria for No Evidence of Disease Activity-3 (NEDA-3) or NEDA-4, improvement on the fatigue symptom and impact questionnaire-relapsing multiple sclerosis (FSIQ-RMS) scale, reduction or absence of relapses, improvement or maintenance on the six-minute walk test or 12-Item Multiple Sclerosis Walking Scale, improvement on the Multiple Sclerosis Functional Composite (MSFC) score, and/or attenuation of brain volume loss, OR Patient experienced stabilization, slowed progression, or improvement in at least one symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	Initial: Patient has a relapsing form of multiple sclerosis (Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NALDEMEDINE TOSYLATE

Products Affected

- SYMPROIC 0.2 MG TABLET

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

NALOXEGOL OXALATE

Products Affected

- MOVANTIK 12.5 MG TABLET
- MOVANTIK 25 MG TABLET

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

NALTREXONE MICROSPHERES

Products Affected

- VIVITROL 380 MG VIAL-DILUENT W/ SYR NDL,OUTER,SUV

PA Criteria	Criteria Details
Exclusion Criteria	The patient is receiving opioid analgesics. The patient currently has a physiologic opioid dependence. The patient currently has a physiologic opioid dependence (i.e., patient has not completed an adequate opioid-free period). The patient is in acute opioid withdrawal. The patient has failed the naloxone challenge test or has a positive urine screen for opioids. The patient has previously exhibited hypersensitivity to naltrexone, PLG, carboxymethylcellulose, or any other components of the diluent.
Required Medical Information	N/A
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Patient has indication of ALCOHOL DEPENDENCE, AND the patient has 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. Patient has indication of OPIOID DEPENDENCE, AND the patient has been opioid free for a minimum of 7-10 days, AND the patient does not have a current need for opioid analgesics, AND Vivitrol will be used as part of a comprehensive treatment program for opioid dependence that should include a psychosocial support system. Renewal: Documentation provided confirming the patient is currently stable on Vivitrol (naltrexone microspheres) and discontinuation of therapy could lead to harm. (Note: claim history or chart notes required for documentation).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NEDOCROMIL

Products Affected

- ALOCRIL 2% EYE DROPS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Patient has a diagnosis of vernal keratoconjunctivitis, vernal conjunctivitis, and/or vernal keratitis. Patient has had a trial and therapeutic failure, intolerance, or contraindication to at least TWO of the following: azelastine ophthalmic solution, cromolyn sodium ophthalmic solution, epinastine ophthalmic solution.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NITAZOXANIDE

Products Affected

- ALINIA 100 MG/5 ML SUSPENSION
- NITAZOXANIDE 500 MG TABLET

PA Criteria	Criteria Details
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. Patient has a diagnosis of 1. Giardiasis OR 2. Cryptosporidiosis AND B. For 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 OR C. For 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OCTREOTIDE

Products Affected

- SANDOSTATIN LAR DEPOT 10 MG KT SUV,OUTER
- SANDOSTATIN LAR DEPOT 20 MG KT OUTER,SUV
- SANDOSTATIN LAR DEPOT 30 MG KT OUTER,SUV

PA Criteria	Criteria Details
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	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. OTHER DIAGNOSES: treatment of severe diarrhea and flushing episodes associated with metastatic carcinoid tumor, treatment of the profuse watery diarrhea associated with vasoactive intestinal peptide (VIP)-secreting tumor.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OLSALAZINE

Products Affected

- DIPENTUM 250 MG CAPSULE

PA Criteria	Criteria Details
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 Documented trial and therapeutic failure, intolerance, or contraindication to ALL of the following: sulfasalazine (immediate-release/delayed-release), balsalazide, mesalamine ER capsules 0.37g (maintenance of remission). (Note: Chart notes, medical records, or electronic claim history required for documentation.)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OMALIZUMAB

Products Affected

- XOLAIR 150 MG/1.2 ML POWDER VL SUV
- XOLAIR 150 MG/ML SYRINGE SUV, P/F
- XOLAIR 75 MG/0.5 ML SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	NASAL POLYPS: 18 years of age or older. ASTHMA: 6 years of age or older. CSU: 12 years of age or older
Prescriber Restrictions	ASTHMA: Prescribed by or in consultation with a Pulmonologist, Immunologist, or Allergist. CSU: Prescribed by an Allergist, Immunologist, or Dermatologist
Coverage Duration	12 months
Other Criteria	A. Patient has ONE of the following diagnoses: 1. Nasal polyps 2. Chronic spontaneous urticaria 3. Moderate to severe persistent asthma, B. For nasal polyps: Patient had an inadequate response to nasal corticosteroids, AND The requested medication will be utilized as add-on maintenance treatment, C. For chronic spontaneous urticarial: Patients chronic spontaneous urticaria is from an unknown cause and patient is unresponsive to H1 antihistamine treatment (for example, cetirizine, levocetirizine, desloratadine, loratadine, or fexofenadine), D. For moderate-to-severe, persistent asthma: Documented evidence of a specific allergic sensitivity as confirmed by a positive skin test to perennial aeroallergens or radioallergosorbent test, AND Patient has evidence of reversible disease (12 percent or greater improvement in forced expiratory volume following beta2-agonist administration, AND If patient is 6 to less than 12 years of age, patients immunoglobulin E level is 30 IU/mL to 1300 IU/mL, AND If patient is 12 years of age or older, patients immunoglobulin E level is 30 IU/mL to 700 IU/mL, AND If patient has moderate, persistent asthma, documentation has been submitted to confirm patient has failed to respond to treatment for 6 months or greater with ONE of the following: 1.

PA Criteria	Criteria Details
	Moderate-dose inhaled corticosteroid and long-acting beta-agonist 2. Low-moderate dose inhaled corticosteroid, long-acting inhaled beta 2-agonist and leukotriene modifiers, AND If patient has severe persistent asthma, documentation has been submitted to confirm patient has failed to respond to treatment for 6 months or greater with high-dose inhaled corticosteroid, long-acting inhaled beta 2-agonist, and leukotriene modifiers.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY (INJECTABLE) - FULVESTRANT PRIOR AUTHORIZATION POLICY

Products Affected

- FULVESTRANT 250 MG/5 ML SYRINGE SUV, INNER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	1 year
Other Criteria	2. Breast Cancer - Fulvestrant Combination Therapy: A) Patient has recurrent or metastatic hormone receptor (HR)-positive (i.e., estrogen receptor- [ER] or progesterone receptor [PR]-positive) disease AND B) Patient meets ONE of the following criteria (i or ii): i. Patient is a postmenopausal female or a male OR ii. Patient is pre/perimenopausal female and meets one of the following (a or b): a) Patient is receiving ovarian suppression/ovarian ablation with a gonadotropin-releasing hormone (GnRH) agonist, examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), or Zoladex (goserelin acetate subcutaneous implant), OR b) Patient has had surgical bilateral oophorectomy or ovarian irradiation, AND C) Patient meets one of the following criteria (i or ii): i. Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer and meets one of the following criteria (a or b): a) Patient has progressed on or after at least one prior endocrine-based therapy and patient meets one of the following criteria (1 or 2) [Note: Examples of endocrine therapy are tamoxifen, anastrozole, letrozole, exemestane]: (1) Patient has a phosphatidylinositol 4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA)-mutated tumor and the medication is used in combination with Piqray (alpelisib tablets) OR (2) The medication will be used in combination with everolimus OR b)

PA Criteria	Criteria Details
	The medication will be used in combination with a cyclin dependent kinase 4/6 (CDK 4/6) inhibitor or a non-steroidal aromatase inhibitor (i.e., anastrozole or letrozole) [Note: Examples of CDK4/6 inhibitors are Kisqali (ribociclib tablets), Ibrance (palbociclib capsules), Verzenio (abemaciclib tablets).] OR ii. Patient has human epidermal growth factor receptor 2 (HER2)-positive breast cancer and the medication is used in combination with a trastuzumab product. 3. Endometrial Carcinoma. 4. Ovarian/Fallopian Tube/Primary Peritoneal Cancer: A) Patient has recurrent low-grade serous carcinoma. 5. Uterine Sarcoma: A) Patient meets one of the following criteria (i, ii, or ii): i. Patient has low-grade endometrial stromal sarcoma OR ii. Patient has adenosarcoma without sarcomatous overgrowth OR iii. Patient has hormone receptor positive uterinesarcoma.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Endometrial Carcinoma. Ovarian/Fallopian Tube/Primary Peritoneal Cancer. Uterine Sarcoma

ONCOLOGY (INJECTABLE) - TRASTUZUMAB PRODUCTS PRIOR AUTHORIZATION POLICY

Products Affected

- HERCEPTIN 150 MG VIAL P/F, SDV

PA Criteria	Criteria Details
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	1 year
Other Criteria	1. Breast Cancer: A) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND B) Patient meets ONE of the following criteria (i or ii): i. trastuzumab is used for neoadjuvant (preoperative)/adjuvant therapy, OR ii. trastuzumab is used for recurrent or metastatic disease. 2. Gastric, Esophageal, or Gastroesophageal Junction Cancer: A) Patient has locally advanced or metastatic disease, AND B) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND C) Patient meets the following criteria (i and ii): i. Trastuzumab will be used as first-line therapy, AND ii. Trastuzumab will be used in combination with chemotherapy. Note: Examples of chemotherapy are cisplatin, oxaliplatin, capecitabine, 5-fluorouracil (5-FU). 3. Biliary Tract Cancer: A) Patient has unresectable or metastatic disease, AND B) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND C) The medication will be used in combination with Perjeta (pertuzumab intravenous infusion), AND D) The patient has tried one systemic regimen, Note: Examples of a systemic regimen include: gemcitabine and cisplatin, 5-fluorouracil and oxaliplatin, capecitabine and oxaliplatin, or gemcitabine and oxaliplatin. 4. Colon or Rectal Cancer: A) Patient has advanced or metastatic disease, AND B) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND C) The medication is used in combination with Perjeta

PA Criteria	Criteria Details
	(pertuzumab intravenous infusion) or lapatinib. 5. Endometrial Carcinoma: A) Patient has advanced or recurrent uterine serous carcinoma, AND B) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND C) Trastuzumab will be used in combination with chemotherapy, Note: Examples of chemotherapy are carboplatin, paclitaxel. 6. Salivary Gland Tumor: A) Patient has recurrent, unresectable, or metastatic disease, AND B) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Biliary Tract Cancer, Colon or Rectal Cancer, Endometrial Carcinoma, Salivary Gland Tumor

ONCOLOGY (INJECTABLE)- GONADOTROPIN-RELEASING HORMONE ANALOGS PRIOR AUTHORIZATION POLICY

Products Affected

- ELIGARD 22.5 MG SYRINGE KIT OUTER, SUV
- ELIGARD 30 MG SYRINGE KIT OUTER,SUV
- ELIGARD 45 MG SYRINGE KIT OUTER, SUV
- ELIGARD 7.5 MG SYRINGE KIT OUTER,SUV

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	None
Prescriber Restrictions	Prostate Cancer: prescribed by or in consultation with an oncologist or urologist. Head and Neck Cancer - Salivary Gland Tumors: prescribed by or in consultation with an oncologist.
Coverage Duration	1 year
Other Criteria	For Camcevi, Eligard, Leuprolide Depot, Firmagon, or Trelstar: diagnosis of Prostate Cancer. For Camcevi or Eligard: A) Diagnosis of Head and Neck Cancer - Salivary Gland Tumors, AND B) Patient has recurrent, unresectable or metastatic disease AND C) Patient has androgen receptor-positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Head and Neck Cancer - Salivary Gland Tumors.

ONCOLOGY- ABIRATERONE ACETATE (GENERIC) PRIOR AUTHORIZATION POLICY

Products Affected

- ABIRATERONE ACETATE 250 MG TAB
- ABIRATERONE ACETATE 500 MG TAB

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Prostate Cancer (Very-High-Risk Group): 2 years. All others: 1 year
Other Criteria	A. Patient has ONE of the following: 1. Prostate Cancer - Metastatic, Castration-Resistant (mCRPC) 2. Prostate Cancer - Metastatic, Castration-Sensitive (mCSPC) 3. Prostate Cancer (Regional Risk Group) 4. Prostate Cancer (Very-High-Risk Group). B. mCRPC: 1. The medication is used in combination with prednisone or dexamethasone, AND 2. Patient meets ONE of the following criteria (i, ii, or iii): i. The medication is concurrently used with a gonadotropin-releasing hormone (GnRH) agonist. Note: Examples of GnRH agonists include: Lupron (leuprolide for injection), Lupron Depot (leuprolide acetate for depot suspension), Trelstar (triptorelin pamoate for injectable suspension), Zoladex (goserelin acetate implant), Vantas (histrelin acetate subcutaneous implant), OR ii. The medication is concurrently used with Firmagon (degarelix for injection), OR iii. Patient has had a bilateral orchiectomy. C. mCSPC: 1. The medication is used in combination with prednisone, AND 2. Patient meets ONE of the following criteria (i, ii, or iii): i. The medication is concurrently used with a gonadotropin-releasing hormone (GnRH) agonist, OR ii. The medication is concurrently used with Firmagon (degarelix for injection), OR iii. Patient has had a bilateral orchiectomy. D. Prostate Cancer (Regional Risk Group): 1. The medication is used in combination with prednisone, AND 2. Patient has regional lymph node metastases and no

PA Criteria	Criteria Details
	distant metastases, AND 3. Patient meets one of the following criteria (i, ii, or iii): i. The medication is concurrently used with a gonadotropin-releasing hormone (GnRH) agonist, OR ii. The medication is concurrently used with Firmagon (degarelix for injection), OR iii. Patient has had a bilateral orchiectomy. E. Prostate Cancer (Very-High-Risk Group): 1. According the prescriber, the patient is in the very-high-risk group. Note: Very-high-risk group includes patients that have one of the following: primary Gleason pattern 5, 2 or 3 high-risk features, greater than 4 cores with Grade Group 4 or 5, tumor that invades seminal vesicles, tumor that is fixed or invades adjacent structures other than seminal vesicles such as external sphincter, rectum, bladder, levator muscles, and/or pelvic wall, AND 2. The medication is used in combination with external beam radiation therapy, AND 3. Patient meets one of the following criteria (i, ii, or iii): i. The medication is concurrently used with a gonadotropin-releasing hormone (GnRH) agonist, OR ii. The medication is concurrently used with Firmagon (degarelix for injection), OR iii. Patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Prostate Cancer (Regional Risk Group), Prostate Cancer (Very-High-Risk Group)

ONCOLOGY- ALECENSA PRIOR AUTHORIZATION POLICY

Products Affected

- ALECENSA 150 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Non-Small Cell Lung Cancer: A) Patient has advanced or metastatic disease AND B) Patient has anaplastic lymphoma kinase (ALK)-positive disease AND C) The mutation was detected by an approved test. 2. Anaplastic Large Cell Lymphoma: A) Patient has anaplastic lymphoma kinase (ALK)-positive disease, AND B) Patient meets one of the following criteria (i or ii): i. Patient has relapsed disease OR ii. Patient has refractory disease. 3. Erdheim-Chester Disease: A) Patient has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. 4. Inflammatory Myofibroblastic Tumor: A) Patient has anaplastic lymphoma kinase (ALK)-positive disease AND B) Patient meets one of the following criteria (i or ii): i. Patient has advanced, recurrent, or metastatic disease OR ii. The tumor is inoperable.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anaplastic Large Cell Lymphoma. Erdheim-Chester Disease. Inflammatory Myofibroblastic Tumor.

ONCOLOGY- BEXAROTENE (ORAL) PRIOR AUTHORIZATION

Products Affected

- BEXAROTENE 75 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or a dermatologist.
Coverage Duration	1 year
Other Criteria	Cutaneous T-Cell Lymphoma: A) Patient has cutaneous manifestations/lesions.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- BOSULIF PRIOR AUTHORIZATION POLICY

Products Affected

- BOSULIF 100 MG TABLET
- BOSULIF 400 MG TABLET
- BOSULIF 500 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Chronic Myeloid Leukemia: Patient has Philadelphia chromosome-positive chronic myeloid leukemia. 2. Acute Lymphoblastic Leukemia: Patient has Philadelphia chromosome-positive acute lymphoblastic leukemia, AND Patient has tried at least one other tyrosine kinase inhibitor for Philadelphia chromosome-positive acute lymphoblastic leukemia. Note: Examples include imatinib and Sprycel (dasatinib tablets). 3. Myeloid/Lymphoid Neoplasms with Eosinophilia: The tumor has an ABL1 rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Acute Lymphoblastic Leukemia. Myeloid/Lymphoid Neoplasms with Eosinophilia.

ONCOLOGY- CAPECITABINE PRIOR AUTHORIZATION

Products Affected

- CAPECITABINE 150 MG TABLET
- CAPECITABINE 500 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Breast Cancer 2. Colon Cancer 3. Esophageal and Esophagogastric Junction Cancers 4. Gastric Cancer 5. Pancreatic Adenocarcinoma
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Ampullary Adenocarcinoma, Anal Carcinoma, Central Nervous System Cancers, Gestational Trophoblastic Neoplasia, Head and Neck Cancers, Hepatobiliary Cancers, Neuroendocrine and Adrenal Tumors, Occult Primary, Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer, Penile Cancer, Rectal Cancer, Small Bowel Adenocarcinoma, Squamous Cell Skin Cancer, Thymomas and Thymic Carcinomas

ONCOLOGY- CAPRELSA PRIOR AUTHORIZATION POLICY

Products Affected

- CAPRELSA 100 MG TABLET
- CAPRELSA 300 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Thyroid Carcinoma, Medullary. 2. Thyroid Carcinoma, Differentiated: A) Patient has differentiated thyroid carcinoma [Note: Examples of differentiated thyroid carcinoma include papillary, follicular, and oncocytic carcinoma (formerly Hurthle cell carcinoma)] AND B) The disease is refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Thyroid Carcinoma, Differentiated

ONCOLOGY- COMETRIQ PRIOR AUTHORIZATION POLICY

Products Affected

- CABOMETYX 20 MG TABLET
- CABOMETYX 40 MG TABLET
- CABOMETYX 60 MG TABLET
- COMETRIQ 100 MG DAILY-DOSE PK
- COMETRIQ 140 MG DAILY-DOSE PK
- COMETRIQ 60 MG DAILY-DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	Metastatic Castration-Resistant Prostate Cancer (mCRPC).
Required Medical Information	N/A
Age Restrictions	Thyroid Carcinoma (Medullary) AND Non-Small Cell Lung Cancer: 18 years of age or older. Thyroid Carcinoma (Differentiated): 12 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Thyroid Carcinoma, Medullary. 2. Non-Small Cell Lung Cancer: Patient has RET gene rearrangements. 3. Thyroid Carcinoma, Differentiated: Patient has differentiated thyroid carcinoma. Note: Examples of differentiated thyroid carcinoma include papillary, follicular, and oncocytic carcinoma (formerly Hurthle cell carcinoma), AND The disease is refractory to radioactive iodine therapy, AND Patient has tried Lenvima (lenvatinib capsules) or Nexavar (sorafenib tablets).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Non-Small Cell Lung Caner. Thyroid Carcinoma, Differentiated.

ONCOLOGY- ERIVEDGE PRIOR AUTHORIZATION POLICY

Products Affected

- ERIVEDGE 150 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	1. Basal Cell Carcinoma (Locally Advanced or Metastatic), in a Patient with Disease Progression While on Odomzo (sonidegib capsules). Note: This does not apply to a patient already started on Erivedge. 2. Metastatic Colorectal Cancer. 3. Ovarian Cancer.
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Basal Cell Carcinoma, Locally Advanced. Initial Therapy: Patient meets one of the following (a or b): a) Patient has recurrent basal cell carcinoma following surgery or radiation therapy, OR b) Patient meets BOTH of the following [(1) and (2)]: (1) Patient is not a candidate for surgery, AND (2) According to the prescriber, the patient is not a candidate for radiation therapy. Renewal: Patient is Currently Receiving Erivedge. 2. Basal Cell Carcinoma, Metastatic (Note: This includes primary or recurrent nodal metastases and distant metastastatic disease). 3. Central Nervous System Cancer (Note: This includes brain and spinal cord tumors.): Patient has medulloblastoma AND Patient has tried at least one chemotherapy agent. Note: Examples of chemotherapy include etoposide, carboplatin, cisplatin, AND According to the prescriber, the patient has a mutation of the sonic hedgehog pathway.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Central Nervous System Cancer

ONCOLOGY- ERLEADA PRIOR AUTHORIZATION POLICY

Products Affected

- ERLEADA 60 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Prostate Cancer - Non-Metastatic, Castration-Resistant: A) Patient meets ONE of the following criteria (i, ii, or iii): i. The medication is used in combination with a gonadotropin-releasing hormone (GnRH) agonist [Note: Examples of GnRH agonists include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant).] OR ii. The medication is concurrently used with Firmagon (degarelix subcutaneous injection) OR iii. Patient has had a bilateral orchiectomy. 2. Prostate Cancer - Metastatic, Castration-Sensitive: A) Patient meets ONE of the following criteria (i, ii, or iii): i. The medication is used in combination with a gonadotropin-releasing hormone (GnRH) agonist [Note: Examples of GnRH agonists include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant)] OR ii. The medication is concurrently used with Firmagon (degarelix subcutaneous injection) OR iii. Patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

ONCOLOGY- ERLOTINIB PRIOR AUTHORIZATION POLICY

Products Affected

- ERLOTINIB HCL 100 MG TABLET
- ERLOTINIB HCL 150 MG TABLET
- ERLOTINIB HCL 25 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Breast Cancer. Colon cancer, Advanced. Glioblastoma Multiforme (GBM). Head and Neck Cancer, Squamous Cell, Recurrent and/or Metastatic. Hepatocellular Carcinoma, Advanced. Renal Cell Carcinoma, Advanced - Clear Cell Histology
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Non-Small Cell Lung Cancer: A) Patient has advanced or metastatic disease, AND B) Patient has sensitizing EGFR mutation-positive non-small cell lung cancer as detected by an approved test, Note: Examples of sensitizing EGFR mutation-positive non-small cell lung cancer include the following: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X, and S768I. 2. Pancreatic Cancer: A) Patient has locally advanced, metastatic, or recurrent disease, AND B) The medication is used in combination with gemcitabine. Bone Cancer: A) Patient has chordoma AND B) Patient has tried at least one previous therapy. 4. Renal Cell Carcinoma: A) Patient meets one of the following criteria (i or ii): i. Patient has recurrent or advanced renal cell carcinoma of non-clear cell histology OR ii. Patient meets both of the following criteria (a and b): a. Patient has hereditary leiomyomatosis and renal cell carcinoma AND b. The medication is used in combination with bevacizumab. 5. Vulvar Cancer: A) Patient has advanced, recurrent, or metastatic disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	Bone Cancer. Renal Cell Carcinoma. Vulvar Cancer.

ONCOLOGY- EVEROLIMUS (GENERIC) PRODUCTS PRIOR AUTHORIZATION POLICY

Products Affected

- EVEROLIMUS 1 MG TABLET
- EVEROLIMUS 10 MG TABLET OUTER
- EVEROLIMUS 2 MG TAB FOR SUSP INNER
- EVEROLIMUS 2.5 MG TABLET OUTER
- EVEROLIMUS 3 MG TAB FOR SUSP INNER
- EVEROLIMUS 5 MG TAB FOR SUSP INNER
- EVEROLIMUS 5 MG TABLET OUTER
- EVEROLIMUS 7.5 MG TABLET OUTER

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	A. Patient has ONE of the following: 1. Breast cancer 2. Neuroendocrine Tumors of the Pancreas, Gastrointestinal Tract, Lung, and Thymus (Carcinoid Tumors) 3. Renal Cell Carcinoma 4. Tuberous Sclerosis Complex-Associated Renal Angiomyolipoma 5. Tuberous Sclerosis Complex-Associated Subependymal Giant Cell Astrocytoma (SEGA) 6. Tuberous Sclerosis Complex-Associated Partial Onset Seizures 7. Endometrial Carcinoma 8. Gastrointestinal Stromal Tumors 9. Histiocytic Neoplasm 10. Classic Hodgkin Lymphoma 11. Uterine Sarcoma 12. Soft Tissue Sarcoma 13. Thymomas and Thymic Carcinomas 14. Thyroid Carcinoma, Differentiated 15. Waldenstroms Macroglobulinemia/Lymphoplasmacytic Lymphoma. B. Breast Cancer: 1. Recurrent or metastatic, hormone receptor positive (HR+) [such as, estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease, AND 2. Has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND 3. Has tried at least one prior endocrine therapy (for example, anastrozole, letrozole, or tamoxifen), AND 4. ONE of the following conditions: i. Postmenopausal woman or a man, OR ii. Pre/perimenopausal woman and one of the following: a. Patient is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist such as leuprolide acetate, Lupron Depot, Trelstar etc. OR b) Past surgical bilateral oophorectomy or ovarian irradiation, AND 5. ONE of the following conditions: i. Medication will be used in combination with exemestane and patient meets one of the following (a or b): a. Patient is a man and is receiving a GnRH analog such as leuprolide acetate, Lupron Depot, Trelstar etc. OR b. Patient is a woman

PA Criteria	Criteria Details
	OR ii. Medication will be used in combination with fulvestrant or tamoxifen, AND 6. Patient has not had disease progression while on everolimus.
Age Restrictions	18 years of age and older for all EXCEPT Tuberous Sclerosis Complex-Associated SEGA, Tuberous Sclerosis Complex-Associated Partial Onset Seizures, Tuberous Sclerosis Complex-Associated Renal Angiomyolipoma
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	C. Renal Cell Carcinoma: 1. Patient has relapsed or Stage IV disease, AND 2. ONE of the following criteria (i or ii): i. Patient has non-clear cell disease, OR ii. Both of the following: a. Patient has clear cell disease, AND b. Patient has tried at least one prior systemic therapy such as Inlyta, Lenvima, Keytruda etc. D. Tuberous Sclerosis Complex-Associated SEGA: 1. Therapeutic intervention is required but SEGA cannot be curatively resected. E. Endometrial Carcinoma: 1. Medication will be used in combination with letrozole. F. Gastrointestinal Stromal Tumors: 1. Patient tried each of following (i, ii, iii, and iv): i. One of imatinib or Ayvakit (avapritinib tablets), AND ii. One of Sutent (sunitinib capsules) or Sprycel (dasatinib tablets), AND iii. Stivarga (regorafenib tablets), AND iv. Qinlock (ripretinib tablets), AND 2. Medication will be used in combination with imatinib, Sutent (sunitinib capsules), or Stivarga (regorafenib tablets). G. Histiocytic Neoplasm: 1. One of the following (i, ii, or iii): i. Patient has Langerhans cell histiocytosis and one of the following: a) Bone disease, OR b) Central nervous system lesions, OR c) Multisystem disease, OR d) Pulmonary disease, OR ii. Patient has Erdheim-Chester disease, OR iii. Patient has Rosai-Dorfman disease, AND 3. Patient has a PIK3CA mutation. H. Classic Hodgkin Lymphoma: 1. Patient has relapsed or refractory disease. I. Uterine Sarcoma: 1. Patient has advanced, recurrent, metastatic, or inoperable disease, AND 2. Patient has a perivascular epithelioid cell tumor (PEComa), AND 3. Patient has tried at least one systemic regimen. Note: Examples of systemic regimen include doxorubicin, docetaxel, gemcitabine, ifosfamide, dacarbazine. J. Soft Tissue Sarcoma: 1. ONE of the following (i or ii): i. Perivascular epitheloid cell tumor (PEComa), OR ii. Recurrent angiomyolipoma/lymphangioleiomyomatosis. K. Thymomas and Thymic Carcinomas: 1. One of the following (i or ii): i. Patient has tried chemotherapy. Note: Examples are cisplatin, doxorubicin, and cyclophosphamide, cisplatin plus etoposide, carboplatin plus paclitaxel, OR

PA Criteria	Criteria Details
	ii. Patient cannot tolerate chemotherapy. L. Thyroid Carcinoma, Differentiated: Note: Examples of differentiated thyroid carcinoma include papillary, follicular, and Hurthle cell thyroid carcinoma, 1. Disease is refractory to radioactive iodine therapy. M. Waldenstroms Macroglobulinemia/Lymphoplasmacytic Lymphoma: 1. One of the following (i or ii): i. Patient has not responded to primary therapy. Note: Examples of primary therapy are bortezomib, dexamethasone, and rituximab, bendamustine and rituximab, cyclophosphamide, rituximab and dexamethasone, Imbruvica (ibrutinib capsules), and Brukinsa (zanubrutinib capsules), OR ii. Patient has progressive or relapsed disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Endometrial Carcinoma, Gastrointestinal Stromal Tumors, Histiocytic Neoplasm, Soft Tissue Sarcoma, Thymomas and Thymic Carcinomas, Thyroid Carcinoma, Differentiated, Classic Hodkin Lymphona. Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma.

ONCOLOGY- GILOTRIF PRIOR AUTHORIZATION POLICY

Products Affected

- GILOTRIF 20 MG TABLET
- GILOTRIF 30 MG TABLET
- GILOTRIF 40 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Non-Small Cell Lung Cancer - Epidermal Growth Factor Receptor (EGFR) Mutation-Positive: A) Patient has advanced or metastatic disease AND B) Patient has sensitizing EGFR mutation-positive non-small cell lung cancer as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive non-small cell lung cancer include the following: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X, and S768I. 2. Non-Small Cell Lung Cancer - Squamous Cell Carcinoma: A) Patient has metastatic squamous cell carcinoma AND B) Patient has disease progression after treatment with platinum-based chemotherapy. 3. Head and Neck Cancer: A) Patient has non-nasopharyngeal head and neck cancer, examples of non-nasopharyngeal head and neck cancer are lip, oral cavity, oropharynx, hypopharynx, glottis, larynx, supraglottic larynx, ethmoid sinus, maxillary sinus, occult primary AND B) Patient has disease progression on or after platinum-based chemotherapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Head and Neck Cancer

ONCOLOGY- IBRANCE PRIOR AUTHORIZATION POLICY

Products Affected

- IBRANCE 100 MG CAPSULE
- IBRANCE 100 MG TABLET INNER
- IBRANCE 125 MG CAPSULE
- IBRANCE 125 MG TABLET INNER
- IBRANCE 75 MG CAPSULE
- IBRANCE 75 MG TABLET INNER

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Breast Cancer in Women: A) Patient has recurrent or metastatic disease, AND B) Patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease, AND C) Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND D) Patient meets ONE of the following criteria (i or ii): i. Patient is postmenopausal OR ii. Patient is pre/perimenopausal and meets one of the following (a or b): a) Patient is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, note: Examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous injection), OR b) Patient has had surgical bilateral oophorectomy or ovarian irradiation, AND E) Patient meets ONE of the following criteria (i or ii): i. Ibrance will be used in combination with anastrozole, exemestane, or letrozole, OR ii. Ibrance will be used in combination with fulvestrant. 2. Breast Cancer in Men: A) Patient has

PA Criteria	Criteria Details
	recurrent or metastatic disease, AND B) Patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease, AND C) Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND D) Patient meets ONE of the following criteria (i or ii): i. Patient meets BOTH of the following criteria (a and b): a) Patient is receiving a gonadotropin-releasing hormone (GnRH) analog, Note: Examples of a GnRH analog include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Firmagon (degarelix acetate subcutaneous injection), Orgovyx (relugolix tablet), AND b) Ibrance will be used in combination with anastrozole, exemestane, or letrozole, OR ii. Ibrance will be used in combination with fulvestrant. 3. Liposarcoma: A) Patient has well-differentiated/dedifferentiated liposarcoma.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Liposarcoma

ONCOLOGY- ICLUSIG PRIOR AUTHORIZATION POLICY

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Acute Lymphoblastic Leukemia: A) Patient has Philadelphia chromosome-positive acute lymphoblastic leukemia AND B) Patient meets one of the following (i or ii): i. The acute lymphoblastic leukemia is T315I-positive OR ii. Patient has tried at least two other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive acute lymphoblastic leukemia. Note: Examples include imatinib tablets and Sprycel (dasatinib tablets). 2. Chronic Myeloid Leukemia: A) Patient has Philadelphia chromosome-positive chronic myeloid leukemia, AND B) Patient meets one of the following criteria (i, ii or iii): i. The chronic myeloid leukemia is T315I-positive, OR ii. Patient has tried at least two other tyrosine kinase inhibitors indicated for use in Philadelphia chromosome-positive chronic myeloid leukemia (Note: Examples include imatinib, Sprycel (dasatinib tablets), and Tasigna (nilotinib capsules)). OR iii. Patient meets the following criteria (a and b): a) Patient has accelerated-phase CML or blast-phase CML, AND b) No other tyrosine kinase inhibitor is indicated. 3. Myeloid/Lymphoid Neoplasms with Eosinophilia: A) Patient meets one of the following (i or ii): i. The tumor has an ABL1 rearrangement OR ii. The tumor has an FGFR1 rearrangement. 4. Gastrointestinal Stromal Tumor: A)

PA Criteria	Criteria Details
	Patient has tried each of the following (i, ii, iii, and iv): i. One of imatinib or Ayvakit (avapritinib tablets), AND ii. One of sunitinib or Sprycel (dasatinib tablets), AND iii. Stivarga (regorafenib tablets), AND iv. Qinlock (ripretinib tablets).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Myeloid/Lymphoid Neoplasms with Eosinophilia, Gastrointestinal Stromal Tumor.

ONCOLOGY- IDHIFA PRIOR AUTHORIZATION POLICY

Products Affected

- IDHIFA 100 MG TABLET
- IDHIFA 50 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	none
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Acute Myeloid Leukemia: Patient has isocitrate dehydrogenase-2 (IDH2)-mutation positive disease as detected by an approved test.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- IMATINIB (GENERIC) PRIOR AUTHORIZATION POLICY

Products Affected

- IMATINIB MESYLATE 100 MG TAB F/C
- IMATINIB MESYLATE 400 MG TAB F/C

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	Melanoma (Cutaneous), Kaposi Sarcoma, Aggressive Systemic Mastocytosis, Dermatofibrosarcoma Protuberans, Hypereosinophilic Syndrome and/or Chronic Eosinophilic Leukemia, Myelodysplastic/Myeloproliferative Disease, Myeloid/Lymphoid Neoplasms with Eosinophilia: 18 years of age and older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	A. Patient has ONE of the following: 1. Acute Lymphoblastic Leukemia. 2. Aggressive Systemic Mastocytosis 3. Chronic Myeloid Leukemia 4. Dermatofibrosarcoma Protuberans 5. Gastrointestinal Stromal Tumors 6. Hypereosinophilic Syndrome and/or Chronic Eosinophilic Leukemia 7. Myelodysplastic/Myeloproliferative Disease 8. Chordoma 9. 9. Desmoid Tumors (Aggressive Fibromatosis) 10. Graft-Versus-Host Disease, Chronic 11. Kaposi Sarcoma 12. 12. Melanoma, Cutaneous 13. Myeloid/Lymphoid Neoplasms with Eosinophilia 14. Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor. B. Acute Lymphoblastic Leukemia: 1. Patient has Philadelphia chromosome-positive acute lymphoblastic leukemia. C. Chronic Myeloid Leukemia: Patient has Philadelphia chromosome-positive chronic myeloid leukemia. D. Myelodysplastic/Myeloproliferative Disease: 1. Condition is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements. E. Graft-Versus-Host Disease, Chronic: 1. Patient has tried at least one conventional systemic treatment for graft-versus-host disease.

PA Criteria	Criteria Details
	Note: Examples include corticosteroids (methylprednisolone, prednisone), cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica (ibrutinib capsules and tablets), low-dose methotrexate, sirolimus, Rezurock (belumosudil tablets), and Jakafi (ruxolitinib tablets). F. Kaposi Sarcoma: 1. Patient has tried at least one medication. Note: Examples include liposomal doxorubicin, paclitaxel, Pomalyst (pomalidomide capsules), lenalidomide, etoposide, and Thalomid (thalidomide capsules), AND 2. Patient has relapsed or refractory disease. G. 12. Melanoma, Cutaneous: 1) Patient has metastatic or unresectable disease, AND 2) Patient has an activating KIT mutation, AND 3) Patient has tried at least one systemic regimen. Note: Examples of a systemic regimen include: Opdivo (nivolumab intravenous infusion) + Yervoy (ipilimumab intravenous infusion), Opdivo + Opdualag (nivolumab/relatlimab-rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo, Tafinlar (dabrafenib capsules) + Mekinist (trametinib tablets), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektovi (binimetinib tablets). H. Myeloid/Lymphoid Neoplasms with Eosinophilia: 1. Patient meets one of the following: i. The tumor has an ABL1 rearrangement OR ii. The tumor has an FIP1L1-PDGFRA or PDGFRB rearrangement. I. Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor: 1. Patient has tried Turalio (pexidartinib capsules), OR 2. Patient cannot take Turalio, according to the prescriber. Note: Examples of reasons for not being able to take Turalio include patients with elevated liver enzymes or concomitant use of medications that are associated with hepatotoxicity.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chordoma, Desmoid Tumors (Aggressive Fibromatosis), Graft-Versus-Host Disease, Chronic, Kaposi Sarcoma, Melanoma (Cutaneous), Myeloid/Lymphoid Neoplasms with Eosinophilia, Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor

ONCOLOGY- IMBRUVICA 140 AND 280 MG TABLETS CARE VALUE POLICY

Products Affected

- IMBRUVICA 140 MG TABLET
- IMBRUVICA 280 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	A. Patient has tried Imbruvica 140 mg capsules, AND b. Patient has ONE of the following: 1. Chronic Lymphocytic Leukemia 2. Graft-Versus-Host Disease, Chronic 3. Mantle Cell Lymphoma 4. Marginal Zone Lymphoma 5. Small Lymphocytic Lymphoma 6. Waldenstrom Macroglobulinemia 7. B-Cell Lymphoma 8. Central Nervous System Lymphoma (Primary) 9. Hairy Cell Leukemia.
Age Restrictions	Graft-Versus-Host Disease, Chronic: 1 year of age and older, ALL others: 18 years of age and older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	B. Graft-Versus-Host Disease, Chronic: 1. Patient tried at least one conventional systemic treatment for graft-versus-host disease. Note: Examples of conventional systemic treatments include: corticosteroids (methylprednisolone, prednisone), imatinib, low-dose methotrexate, sirolimus, mycophenolate mofetil, and Jakafi (ruxolitinib tablets). C. Mantle Cell Lymphoma: 1) Patient is continuing therapy with Imbruvica, AND 2) Patient meets one of the following criteria: (i or ii): i. Patient meets one of the following criteria (a or b): a) Patient has tried at least one systemic regimen (Examples of a systemic regimen include one or more of the following products: bendamustine, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone, cytarabine, carboplatin, cisplatin, oxaliplatin, or lenalidomide.), OR b) According to the prescriber, patient is not a candidate for a systemic regimen (i.e., an elderly person who is frail), OR ii. Imbruvica is used in combination with rituximab prior to induction therapy. Examples of induction therapy include: rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone. D)

PA Criteria	Criteria Details
	Marginal Zone Lymphoma: Note: Marginal zone lymphoma includes gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma. 1) Patient is continuing therapy with Imbruvica, AND 2) Patient has tried at least one systemic regimen. Examples of a systemic regimen include one or more of the following products: bendamustine, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone, or lenalidomide. E. B-Cell Lymphoma: Note: Examples of B-cell lymphomas include: diffuse large B-cell lymphomas, Acquired Immune Deficiency Syndrome (AIDS)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, double/triple hit lymphoma, and high-grade B-cell lymphoma, AND 1. Patient tried at least one systemic regimen. Note: Examples of a systemic regimen includes one or more of the following products: cisplatin, cytarabine, rituximab, oxaliplatin, gemcitabine, ifosfamide, carboplatin, etoposide, or rituximab. F. Central Nervous System Lymphoma (Primary): 1. Patient meets one of the following criteria (i or ii): i. According to the prescriber, the patient is not a candidate for or is intolerant to high-dose methotrexate, OR ii. Patient tried at least one therapy. Note: Examples of therapies include methotrexate, rituximab, vincristine, procarbazine, cytarabine, thiotepa, carmustine, intrathecal methotrexate, cytarabine, or rituximab. G. Hairy Cell Leukemia: 1. Patient tried at least two systemic regimens. Note: Examples of a systemic regimen include one or more of the following products: cladribine, Nipent (pentostatin injection), rituximab, or Pegasys (peginterferon alfa-2a subcutaneous injection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	B-Cell Lymphoma, Central Nervous System Lymphoma (Primary), Hairy Cell Leukemia, Mantle Cell Lymphoma, Marginal Zone Lymphoma

ONCOLOGY- IMBRUVICA PRIOR AUTHORIZATION POLICY

Products Affected

- IMBRUVICA 140 MG CAPSULE
- IMBRUVICA 420 MG TABLET
- IMBRUVICA 70 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	Graft-Versus-Host Disease, Chronic: 1 year of age and older, ALL others: 18 years of age and older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	A. Patient has ONE of the following: 1. Chronic Lymphocytic Leukemia 2. Graft-Versus-Host Disease, Chronic 3. Mantle Cell Lymphoma 4. Marginal Zone Lymphoma 5. Small Lymphocytic Lymphoma 6. Waldenstrom Macroglobulinemia 7. B-Cell Lymphoma 8. Central Nervous System Lymphoma (Primary) 9. Hairy Cell Leukemia. B. Graft-Versus-Host Disease, Chronic: 1. Patient tried at least one conventional systemic treatment for graft-versus-host disease. Note: Examples of conventional systemic treatments include: corticosteroids (methylprednisolone, prednisone), imatinib, low-dose methotrexate, sirolimus, mycophenolate mofetil, and Jakafi (ruxolitinib tablets). C. Mantle Cell Lymphoma: 1. Patient meets one of the following criteria: (i or ii): i. Patient tried at least one systemic regimen. Note: Examples of a systemic regimen include one or more of the following products: bendamustine, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone, cytarabine, carboplatin, cisplatin, oxaliplatin, or lenalidomide, OR ii. Imbruvica is used in combination with rituximab prior to induction therapy. Note: Examples of induction therapy include: rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone. D. Marginal Zone Lymphoma: Note:

PA Criteria	Criteria Details
	Marginal zone lymphoma includes gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma, AND 1. Patient has tried at least one systemic regimen. Note: Examples of a systemic regimen include one or more of the following products: bendamustine, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone, or lenalidomide. E. B-Cell Lymphoma: Note: Examples of B-cell lymphomas include: diffuse large B-cell lymphomas, Acquired Immune Deficiency Syndrome (AIDS)-related B-cell lymphomas, post-transplant lymphoproliferative disorders, double/triple hit lymphoma, and high-grade B-cell lymphoma, AND 1. Patient tried at least one systemic regimen. Note: Examples of a systemic regimen includes one or more of the following products: cisplatin, cytarabine, rituximab, oxaliplatin, gemcitabine, ifosfamide, carboplatin, etoposide, or rituximab. F. Central Nervous System Lymphoma (Primary): 1. Patient meets one of the following criteria (i or ii): i. According to the prescriber, the patient is not a candidate for or is intolerant to high-dose methotrexate, OR ii. Patient tried at least one therapy. Note: Examples of therapies include methotrexate, rituximab, vincristine, procarbazine, cytarabine, thiotepa, carmustine, intrathecal methotrexate, cytarabine, or rituximab. G. Hairy Cell Leukemia: 1. Patient tried at least two systemic regimens. Note: Examples of a systemic regimen include one or more of the following products: cladribine, Nipent (pentostatin injection), rituximab, or Pegasys (peginterferon alfa-2a subcutaneous injection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	B-Cell Lymphoma, Central Nervous System Lymphoma (Primary), Hairy Cell Leukemia

ONCOLOGY- INLYTA PRIOR AUTHORIZATION POLICY

Products Affected

- INLYTA 1 MG TABLET
- INLYTA 5 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Renal Cell Cancer: Patient has relapsed or advanced disease. 2. Thyroid Carcinoma, Differentiated: Patient has differentiated thyroid carcinoma, examples of differentiated thyroid carcinoma include papillary, follicular, and oncocytic carcinoma (formerly Hurthle cell carcinoma) AND The disease is refractory to radioactive iodine therapy. 3. Soft Tissue Sarcoma: Patient has alveolar soft part sarcoma AND B) The medication will be used in combination with Keytruda (pembrolizumab intravenous infusion).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Thyroid Carcinoma, Differentiated. Soft Tissue Sarcoma.

ONCOLOGY- JAKAFI PRIOR AUTHORIZATION POLICY

Products Affected

- JAKAFI 10 MG TABLET
- JAKAFI 15 MG TABLET
- JAKAFI 20 MG TABLET
- JAKAFI 25 MG TABLET
- JAKAFI 5 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	Acute and Chronic Graft versus Host Disease: 12 years of age or older. Myelofibrosis (MF), Polycythemia Vera, Chronic Monomyelocytic Leukemia-2, Essential Thrombocythemia, Myeloid or Lymphoid Neoplasms: 18 years of age or older. Acute Lymphoblastic Leukemia: less than 21 years of age
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Graft versus Host Disease, Acute: A) Patient has tried one systemic corticosteroid. 2. Graft versus Host Disease, Chronic: A) Patient has tried one conventional systemic treatment for graft versus host disease. [Note: Examples include systemic corticosteroids (methylprednisolone, prednisone), cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica (ibrutinib capsules and tablets), and imatinib]. 3. Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF. 4. Polycythemia Vera: A) Patient has tried hydroxyurea and Pegasys [peginterferon alfa-2a subcutaneous injection]. 5. Acute Lymphoblastic Leukemia: A) The mutation/pathway is Janus Associated Kinase (JAK)-related. 6. Atypical Chronic Myeloid Leukemia: A) Patient has a CSF3R mutation OR B) Patient has a Janus Associated Kinase 2 (JAK2) mutation. 7. Chronic Monomyelocytic Leukemia-2: A)

PA Criteria	Criteria Details
	Patient is also receiving a hypomethylating agent. [Note: Examples of hypomethylating agents include azacitidine and decitabine]. 8. Essential Thrombocythemia: A) Patient has tried hydroxyurea, peginterferon alfa-2a, or anagrelide. 9. Myeloid or Lymphoid Neoplasms: A) Patient has eosinophilia AND B) The tumor has a Janus Associated Kinase 2 (JAK2) rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Acute Lymphoblastic Leukemia. Atypical Chronic Myeloid Leukemia. Chronic Monomyelocytic Leukemia-2. Essential Thrombocythemia. Myeloid or Lymphoid Neoplasms.

ONCOLOGY- KISQALI CARE VALUE POLICY

Products Affected

- KISQALI 200 MG DAILY DOSE
- KISQALI 400 MG DAILY DOSE OUTER
- KISQALI 600 MG DAILY DOSE OUTER

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	A. Patient meets ONE of the following criteria: i. Patient has been taking Kisqali and is continuing therapy [documentation required], OR ii. Patient will be using Kisqali in combination with an aromatase inhibitor as initial endocrine-based therapy, OR iii. Kisqali will be used in combination with fulvestrant in postmenopausal female or male patients as initial endocrine-based therapy, OR iv. Patient has tried one of Ibrance or Verzenio, AND B. Patient meets ONE of the following: 1. Breast Cancer in Women: Patient has recurrent or metastatic disease, AND Patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease, AND Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND Patient meets ONE of the following criteria (i or ii): i. Patient is postmenopausal, OR ii. Patient is pre/perimenopausal and meets one of the following (a or b): a) Patient is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist. Note: Examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), OR b) Patient has had surgical bilateral oophorectomy or ovarian irradiation, AND Patient meets ONE of the following criteria (i or ii): i. Kisqali will be used in combination with anastrozole, exemestane, or letrozole, OR ii. Kisqali will be used in combination with fulvestrant.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	2. Breast Cancer in Men: Patient has recurrent or metastatic disease, AND Patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease, AND Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND Patient meets ONE of the following criteria (i or ii): i. Patient meets BOTH of the following criteria (a and b): a) Patient is receiving a gonadotropin-releasing hormone (GnRH) analog. Note: Examples of GnRH analog include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Firmagon (degarelix acetate subcutaneous injection), Orgovyx (relugolix tablet), AND b) Kisqali will be used in combination with anastrozole, exemestane, or letrozole, OR ii. Kisqali will be used in combination with fulvestrant.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- LAPATINIB PRIOR AUTHORIZATION POLICY

Products Affected

- LAPATINIB 250 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Head and Neck, Squamous Cell Carcinoma. Urothelial Carcinoma.
Required Medical Information	1. Breast Cancer: A) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease AND B) Patient has recurrent or metastatic breast cancer AND C) Patient meets one of the following criteria (i or ii): i. The patient meets both of the following criteria (a and b): a) The medication will be used in combination with capecitabine or trastuzumab AND b) Patient has tried at least three prior anti-HER2 based regimens [Note: Examples of anti-HER2 regimens include: Perjeta (pertuzumab intravenous infusion) + trastuzumab + docetaxel, Perjeta + trastuzumab + paclitaxel, Enhertu (fam-trastuzumab deruxtecan-nxki intravenous infusion), Kadcyla (ado-trastuzumab emtansine intravenous infusion), Tukysa (tucatinib tablet) + trastuzumab + capecitabine.] OR ii. medication will be used in combination with an aromatase inhibitor (that is, letrozole, anastrozole, or exemestane) AND patient meets the following criteria: a) Patient has hormone receptor-positive (HR+) [i.e., estrogen receptor positive [ER+]- and/or progesterone receptor positive [PR+]]disease AND b) One of the following ([1] [2] or [3]) applies: 1. Patient is a postmenopausal woman OR 2. Patient is a premenopausal or perimenopausal woman and is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, surgical bilateral oophorectomy, or ovarian irradiation [Note: Examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous injection)] OR 3. Patient is a man and is receiving a gonadotropin-releasing hormone (GnRH) analog.[Note: Examples of a GnRH analog include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Firmagon (degarelix acetate subcutaneous injection), Orgovyx (relugolix tablet).]
Age Restrictions	18 years of age or older

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	2. Bone Cancer: A) Patient has recurrent chordoma AND B) Patient has epidermal growth-factor receptor (EGFR)-positive disease. 3. Colon or Rectal Cancer: A) Patient has unresectable, advanced, or metastatic disease AND B) Patient has human epidermal receptor2 (HER2)-amplified disease AND C) Patient has wild-type RAS and BRAF disease AND D) Patient meets ONE of the following (i or ii): i. Patient has tried at least one chemotherapy regimen [Note: Examples of chemotherapy are fluoropyrimidine such as 5-fluorouracil (5-FU), capecitabine, oxaliplatin, irinotecan, or an adjunctive chemotherapy regimen such as FOLFOX (5-FU, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin)]. OR ii. Patient is not a candidate for intensive therapy, according to the prescriber AND E) The medication is used in combination with trastuzumab AND F) Patient has not been previously treated with a HER2-inhibitor. Note: Examples of HER2-inhibitors are trastuzumab products, Nerlynx (neratinib tablets), Kadcyla (ado-trastuzumab emtansine intravenous infusion) Perjeta (pertuzumab intravenous infusion).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Bone Cancer. Colon or Rectal Cancer.

ONCOLOGY- LENALIDOMIDE PRIOR AUTHORIZATION POLICY

Products Affected

- LENALIDOMIDE 10 MG CAPSULE
- LENALIDOMIDE 15 MG CAPSULE
- LENALIDOMIDE 25 MG CAPSULE
- LENALIDOMIDE 5 MG CAPSULE
- REVLIMID 10 MG CAPSULE
- REVLIMID 15 MG CAPSULE
- REVLIMID 2.5 MG CAPSULE
- REVLIMID 20 MG CAPSULE
- REVLIMID 25 MG CAPSULE
- REVLIMID 5 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	1. Follicular Lymphoma: A) Patient meets one of the following: i. Patient is using lenalidomide in combination with rituximab OR ii. Patient has tried at least one other regimen. Examples include bendamustine plus Gazyva (obinutuzumab intravenous infusion) or rituximab, bendamustine plus Gazyva, CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) plus Gazyva or rituximab, CVP (cyclophosphamide, vincristine, prednisone) plus Gazyva or rituximab, chlorambucil with or without rituximab, cyclophosphamide with or without rituximab, rituximab, Gazyva, or Aliqopa (copanlisib intravenous infusion). 2. Mantle Cell Lymphoma: A) Patient meets one of the following: i. Patient is using lenalidomide in combination with rituximab OR ii. Patient has tried at least two other regimens. Examples include HyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone alternating with high-dose methotrexate and cytarabine) + rituximab, the NORDIC regimen (dose-intensified induction immunochemotherapy with rituximab + cyclophosphamide, vincristine, doxorubicin, prednisone alternating with rituximab and high-dose cytarabine), RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone), bendamustine injection plus rituximab, RDHA (rituximab, dexamethasone, cytarabine) + platinum (carboplatin, cisplatin, or oxaliplatin), Imbruvica (ibrutinib capsules and tablets) with or without rituximab, Calquence (acalabrutinib capsules), or Brukinsa (zanubrutinib capsules). 3. Marginal Zone Lymphoma: A) Patient meets one of the following: i. Patient is using

PA Criteria	Criteria Details
	lenalidomide in combination with rituximab, OR ii. Patient has tried least one other regimen. Examples include CHOP + rituximab, bendamustine + rituximab, CVP + rituximab, rituximab, chlorambucil with or without rituximab, cyclophosphamide with or without rituximab, bendamustine + Gazyva (obinutuzumab IV infusion), Copiktra (duvelisib capsules), Aliqopa (copanlisib IV infusion), or Zydelig (idelalisib capsules).
Age Restrictions	18 years of age and older for all indications EXCEPT Langerhans Cell Histiocytosis
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	4. Multiple Myeloma. 5. Myelodysplastic Syndrome: A) Patient meets one of the following: i. Patient has symptomatic anemia, OR ii. Patient has transfusion-dependent anemia, OR iii. Patient has anemia that is not controlled with an erythropoiesis-stimulating agent. Examples include Epogen/Procrit (epoetin alfa injection), Aranesp (darbepoetin alfa injection). 6. B-Cell-Lymphomas (Other): Patient has tried at least one other regimen, examples include RCHOP, dose-adjusted EPOCH with rituximab, RCEPP, DHA plus platinum (carboplatin, cisplatin, oxaliplatin) with or without rituximab, ICE with or without rituximab, RGCVP, GDP with/without rituximab or gemcitabine, dexamethasone, carboplatin with/without rituximab, R-HyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone alternating with high-dose methotrexate and cytarabine), or bendamustine with/without rituximab. 7. Kaposi Sarcoma: A) Patient has relapsed or refractory disease, B) Patient has tried at least one other medication, Examples include liposomal doxorubicin, paclitaxel, Pomalyst, Thalomid, and imatinib. 8. Castlemans Disease: relapsed/refractory or progressive disease. 9. Central Nervous System Lymphoma: Per prescriber the patient has relapsed or refractory disease. 10. Hodgkin Lymphoma, Classical: A) Patient has tried at least three other regimens. Examples include ABVD, BEACOPP, Adcetris (brentuximab vedotin intravenous infusion), Adcetris + AVD, DHAP, ICE, or GVD. 11. Langerhans Cell Histiocytosis: patients with multifocal skin disease. 12. Myelofibrosis: A) Patient meets the following: i. According to the prescriber the patient has anemia AND ii. Patient has serum erythropoietin levels less than 500 mU/mL. B) Patient meets the following: i. According to the prescriber the patient has anemia, AND ii. Patient has serum erythropoietin levels less than 500 mU/mL AND iii. Patient has experienced no response or loss of response to an erythropoiesis-

PA Criteria	Criteria Details
	stimulating agent. 13. Peripheral T-Cell Lymphomas: A) Patient has tried at least one other regimen, examples of regimens include Beleodaq, Adcetris, DHAP, ESHAP, GDP, GemOX (gemcitabine, oxaliplatin), ICE, or Istodax. 14. POEMS Syndrome AND 15. Systemic Light Chain Amyloidosis: Use of lenalidomide in combination with dexamethasone. 16. T-Cell Leukemia/Lymphoma: Patient has tried at least one other regimen, Examples include Adcetris plus CHP (cyclophosphamide, doxorubicin, and prednisone), CHOP, CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, and prednisone), dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, and doxorubicin), HyperCVAD alternating with high-dose methotrexate and cytarabine, or Beleodaq.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	B-Cell-Lymphomas (Other). Kaposi Sarcoma. Castleman's Disease. Central Nervous System Lymphoma. Hodgkin Lymphoma, Classical. Langerhans Cell Histiocytosis. Myelofibrosis. Peripheral T-Cell Lymphomas. POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome. Systemic Light Chain Amyloidosis. T-Cell Leukemia/Lymphoma.

ONCOLOGY- LENVIMA PRIOR AUTHORIZATION POLICY

Products Affected

- LENVIMA 10 MG DAILY DOSE INNER
- LENVIMA 12 MG DAILY DOSE OUTER
- LENVIMA 14 MG DAILY DOSE INNER
- LENVIMA 18 MG DAILY DOSE OUTER
- LENVIMA 20 MG DAILY DOSE INNER
- LENVIMA 24 MG DAILY DOSE INNER
- LENVIMA 4 MG CAPSULE OUTER
- LENVIMA 8 MG DAILY DOSE OUTER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Endometrial Carcinoma: 1) Patient has advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), AND 2) The medication is used in combination with Keytruda (pembrolizumab intravenous injection), AND 3) Patient has tried at least one systemic therapy (Examples of systemic therapy include carboplatin, paclitaxel, docetaxel, cisplatin, doxorubicin, or ifosfamide), AND 4) Patient is not a candidate for curative surgery or radiation. 2. Hepatocellular Cancer: 1) Patient has unresectable or metastatic disease. 3. Renal Cell Cancer: 1) Patient has advanced disease, AND 2) Patient meets ONE of the following (i or ii):i. Lenvima is being used in combination with Keytruda (pembrolizumab intravenous infusion) OR ii. Lenvima is being used in combination with everolimus tablets/Afinitor Disperz (everolimus tablets for oral suspension) AND patient meets one of the following (a or b): a) Patient has clear cell histology and patient has tried one

PA Criteria	Criteria Details
	antiangiogenic therapy (Examples of antiangiogenic therapy include Inlyta (axitinib tablets), Votrient (pazopanib tablets), sunitinib, or Cabometyx (cabozantinib tablets)), por b) Patient has non-clear cell histology. 4. Thyroid Carcinoma, Differentiated: 1) Patient has differentiated thyroid carcinoma (Examples of differentiated thyroid carcinoma include papillary, follicular, and oncocytic carcinoma (formerly Hurthle cell carcinoma)) AND 2) The disease is refractory to radioactive iodine therapy. 5. Melanoma: 1) Patient has unresectable or metastatic melanoma, AND 2) The medication is used in combination with Keytruda (pembrolizumab intravenous injection), AND 3) Patient has disease progression on anti-programmed death receptor-1 (PD-1)/programmed death-ligand 1 (PD-L1)-based therapy (Examples of anti-PD-1/PD-L1 therapies include Opdivo (nivolumab intravenous infusion) + Yervoy (ipilimumab intravenous infusion), Opdualag (nivolumab and relatlimab-rmbw intravenous infusion), Keytruda, Opdivo). 6. Thymic Carcinoma: 1) Patient has tried at least one chemotherapy regimen (Examples of a chemotherapy regimen include carboplatin plus paclitaxel, cisplatin, doxorubicin plus cyclophosphamide, cisplatin plus etoposide). 7. Thyroid Carcinoma, Medullary: 1) Patient has tried at least one systemic therapy (Examples of systemic therapy include Caprelsa (vandetanib tablets), Cometriq (cabozantinib capsules), Retevmo (selpercatinib capsules), and Gavreto (pralsetinib capsules)).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Melanoma. Thymic Carcinoma. Thyroid Carcinoma, Medullary.

ONCOLOGY- LORBRENA PRIOR AUTHORIZATION POLICY

Products Affected

- LORBRENA 100 MG TABLET
- LORBRENA 25 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Non-Small Cell Lung Cancer - Anaplastic Lymphoma Kinase (ALK)-Positive: A) Patient has advanced or metastatic disease AND B) Patient has anaplastic lymphoma kinase (ALK)-positive disease AND C) The mutation was detected by an approved test. 2. Erdheim-Chester Disease: A) Patient has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. 3. Inflammatory Myofibroblastic Tumor: A) Patient has anaplastic lymphoma kinase (ALK)-positive disease, B) Patient meets one of the following criteria (i or ii): i. Patient has advanced, recurrent, or metastatic disease OR ii. The tumor is inoperable. 4. Non-Small Cell Lung Cancer - ROS1 Rearrangement-Positive: A) Patient has advanced or metastatic disease AND B) Patient has ROS1 rearrangement-positive disease AND C) Patient has tried at least one of Xalkori (crizotinib capsules), Zykadia (ceritinib capsules or tablets), or Rozlytrek (entrectinib capsules).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Erdheim-Chester Disease. Inflammatory Myofibroblastic Tumor. Non-Small Cell Lung Cancer - ROS1 Rearrangement-Positive.

ONCOLOGY- LYNPARZA PRIOR AUTHORIZATION POLICY

Products Affected

- LYNPARZA 100 MG TABLET
- LYNPARZA 150 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	1. Breast Cancer (Adjuvant Therapy): Patient has germline BRCA mutation-positive breast cancer, AND Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND Patient meets one of the following criteria (i or ii): i. Patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)] disease and meets one of the following (a or b): a) Patient did not have a pathologic complete response to neoadjuvant therapy, OR b) Patient has node positive disease after receiving adjuvant therapy, OR ii. Patient has hormone receptor negative disease (HR-) and meets both of the following (a and b): a) Patient has tried neoadjuvant or adjuvant therapy, AND b) Patient has residual disease. 2. Breast Cancer (Recurrent or Metastatic Disease): Patient has recurrent or metastatic disease, AND Patient has germline BRCA mutation-positive breast cancer, AND Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer. 3. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer (Maintenance, Monotherapy): Patient meets ONE of the following (i or ii): i. Patient meets both of the following criteria for first-line maintenance therapy (a and b): a) Patient has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test, AND b) Patient is in complete or partial response to first-line platinum-based chemotherapy regimen. Note: Examples are carboplatin with paclitaxel, carboplatin with doxorubicin, docetaxel with carboplatin, OR ii. Patient is in complete or partial response after at least two platinum-based chemotherapy regimens. Note: Examples of platinum-based chemotherapy are carboplatin with gemcitabine, carboplatin with paclitaxel, cisplatin with gemcitabine.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	4. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer (Maintenance, Combination Therapy): The medication is used in combination with bevacizumab, AND Patient has homologous recombination deficiency (HRD)-positive disease as confirmed by an approved test. Note: HRD-positive disease includes patients with BRCA mutation-positive disease, AND Patient is in complete or partial response to first-line platinum-based chemotherapy regimen. Note: Examples of chemotherapy regimens are carboplatin with paclitaxel, carboplatin with doxorubicin, docetaxel with carboplatin. 5. Pancreatic Cancer (Maintenance Therapy): Patient has a germline BRCA mutation-positive metastatic disease, AND The disease has not progressed on at least 16 weeks of treatment with a first-line platinum-based chemotherapy regimen. 6. Prostate Cancer: Patient has metastatic castration resistant prostate cancer, AND Patient meets one of the following criteria (i or ii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog. Note: Examples are leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant), Firmagon (degarelix acetate subcutaneous injection), Orgovyx (relugolix tablets), OR ii. Patient has had a bilateral orchiectomy, AND Patient has germline or somatic homologous recombination repair (HRR) gene-mutated disease, as confirmed by an approved test. Note: HRR gene mutations include BRCA1, BRCA2, ATM, BARD1, BRIP1, CDK12, CHEK1, CHEK2, FANCL, PALB2, RAD51B, RAD51C, RAD51D, or RAD54L, AND Patient does not have a PPP2R2A mutation, AND Patient has been previously treated with at least one androgen receptor-directed therapy. Note: Androgen-receptor-directed therapy includes: abiraterone, Xtandi (enzalutamide capsules and tablets), Nubeqa (darulutamide tablets), or Erleada (apalutamide tablets). 7. Ovarian Cancer (Treatment: Note: This also includes fallopian tube, or primary peritoneal cancer): Patient has a germline BRCA-mutation as confirmed by an approved test, AND Patient has progressed on two or more prior lines of chemotherapy. 8. Uterine Leiomyosarcoma: Patient has BRCA2-altered disease, AND Patient has tried one systemic regimen. Note: Examples of a systemic regimen include one or more of the following products: dacarbazine, docetaxel, doxorubicin, epirubicin, gemcitabine, ifosfamide, vinorelbine.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Ovarian Cancer - Treatment. Uterine Leiomyosarcoma

ONCOLOGY- MEKINIST PRIOR AUTHORIZATION POLICY

Products Affected

- MEKINIST 0.5 MG TABLET
- MEKINIST 2 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Colon or Rectal Cancer
Required Medical Information	1. Melanoma: A) Patient is greater than or equal to 6 years of age AND B) Patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma [Note: This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery.] AND C) Patient has BRAF V600 mutation-positive disease. 2. Solid Tumors Unresectable or Metastatic: [Note: Examples of solid tumors are: biliary tract cancer, brain metastases due to melanoma, high-grade gliomas, differentiated thyroid carcinoma, gastrointestinal stromal tumors, gastric cancer, esophageal and esophagogastric junction cancers, salivary gland tumors, pancreatic adenocarcinoma, neuroendocrine tumors, and ampullary adenocarcinoma.] A) Patient is greater than or equal to 6 years of age AND B) Patient has BRAF V600 mutation-positive disease AND C) The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension) AND D) According to the prescriber, the patient has no satisfactory alternative treatment options. 3. Non-Small Cell Lung Cancer: A) Patient is greater than or equal to 6 years of age AND B) Patient has BRAF V600 mutation-positive disease AND C) The medication is prescribed in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension). 4. Thyroid Carcinoma, Anaplastic: A) Patient is greater than or equal to 6 years of age AND B) Patient has locally advanced or metastatic anaplastic disease AND C) Patient has BRAF V600 mutation-positive disease AND D) The medication is prescribed in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension), unless intolerant. 5. Low Grade Glioma: A) Patient is greater than or equal to 1 year of age AND B) Patient has BRAF V600 mutation-positive disease AND C) The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension) AND D) Patient requires systemic therapy.
Age Restrictions	1 year of age or older

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	6. Histiocytic Neoplasm: A) Patient is greater than or equal to 6 years of age AND B) Patient meets one of the following (i, ii, or iii): i. Patient has Langerhans cell histiocytosis and one of the following (a, b, or c): a) Multisystem disease OR b) Pulmonary disease OR c) Central nervous system lesions OR ii. Patient has Erdheim-Chester disease OR iii. Patient has Rosai-Dorfman disease. 7. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer: A) Patient is greater than or equal to 6 years of age AND B) Patient has recurrent disease AND C) Patient meets ONE of the following (i or ii): i. The medication is used for low-grade serous carcinoma OR ii. The patient meets both of the following (a and b): a) Patient has BRAF V600 mutation-positive disease AND b) The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Histiocytic Neoplasm. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer.

ONCOLOGY- NILUTAMIDE PRIOR AUTHORIZATION POLICY

Products Affected

- NILUTAMIDE 150 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	Prostate Cancer: nilutamide is used concurrently with a luteinizing hormone-releasing hormone (LHRH) agonist. Note: Examples are Lupron (leuprolide subcutaneous injection), Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- NUBEQA PRIOR AUTHORIZATION POLICY

Products Affected

- NUBEQA 300 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Prostate Cancer - Metastatic, Castration-Sensitive: A) The medication is used concurrently with docetaxel AND B) Patient meets ONE of the following criteria (i, ii, or iii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) agonist [Note: Examples of GnRH agonists include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant).] OR ii. The medication is used concurrently with Firmagon (degarelix subcutaneous injection) OR iii. Patient has had a bilateral orchiectomy. 2. Prostate Cancer - Non-Metastatic, Castration-Resistant: A) Patient meets one of the following criteria (i, ii, or iii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) agonist [Note: Examples of GnRH agonists include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant).] OR ii. The medication is used concurrently with Firmagon (degarelix subcutaneous injection) OR iii. Patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

ONCOLOGY- ODOMZO PRIOR AUTHORIZATION POLICY

Products Affected

- ODOMZO 200 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	Basal Cell Carcinoma (Locally Advanced or Metastatic), in a Patient with Disease Progression While on Erivedge (vismodegib capsules). Note: This does not apply to a patient already started on Odomzo. Refer to criteria for Basal Cell Carcinoma, Locally Advanced for a Patient Currently Receiving Odomzo.
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Basal Cell Carcinoma, Locally Advanced. Initial: Patient meets one of the following (a or b): a) Patient has recurrent basal cell carcinoma following surgery or radiation therapy, OR b) Patient meets BOTH of the following [(1) and (2)]: (1) Patient is not a candidate for surgery, AND (2) According to the prescriber, the patient is not a candidate for radiation therapy. Renewal: Patient is Currently Receiving Odomzo. 2. Basal Cell Carcinoma, Metastatic. A. Disease is limited to nodal metastases. Note: This includes primary or recurrent nodal metastases. A patient with distant metastasis does not meet this requirement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Basal Cell Carcinoma, Metastatic.

ONCOLOGY- POMALYST PRIOR AUTHORIZATION POLICY

Products Affected

- POMALYST 1 MG CAPSULE
- POMALYST 2 MG CAPSULE
- POMALYST 3 MG CAPSULE
- POMALYST 4 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older: all indications EXCEPT Central Nervous System Lymphoma
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Kaposi Sarcoma: Patient meets one of the following (i or ii): i. Patient is Human Immunodeficiency Virus (HIV)-negative OR ii. Patient meets both of the following (a and b): a) Patient is HIV-positive AND b) Patient continues to receive highly active antiretroviral therapy. 2. Multiple Myeloma: Patient has received at least one other lenalidomide containing regimen. 3. Central Nervous System Lymphoma: Patient has relapsed or refractory disease. 4. POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome: Use of Pomalyst is in combination with dexamethasone. 5. Systemic Light Chain Amyloidosis: A) Use of Pomalyst is in combination with dexamethasone AND B) Patient has tried at least one other regimen. Note: Examples of regimens include lenalidomide plus dexamethasone/ Velcade (bortezomib injection for intravenous or subcutaneous use), lenalidomide, cyclophosphamide, and dexamethasone/ Velcade with or without dexamethasone/ Velcade, lenalidomide, and dexamethasone/ melphalan and dexamethasone/ Velcade, cyclophosphamide, and dexamethasone/ and

PA Criteria	Criteria Details
	Darzalex (daratumumab intravenous infusion)/Darzalex Faspro (daratumumab and hyaluronidase-fihj subcutaneous injection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Central Nervous System Lymphoma. POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome. Systemic Light Chain Amyloidosis.

ONCOLOGY- SORAFENIB (GENERIC TABLETS) PRIOR AUTHORIZATION POLICY

Products Affected

- SORAFENIB 200 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	1. Hepatocellular Cancer: Patient has unresectable or metastatic disease. 2. Renal Cell Cancer: Patient has relapsed or advanced disease, AND Patient has clear cell histology, AND Patient has tried at least one systemic therapy. Note: Examples of systemic therapy include Inlyta (axitinib tablets), Votrient (pazopanib tablets), Sutent (sunitinib capsules), Cabometyx (cabozantinib tablets). 3. Thyroid Carcinoma, Differentiated: Patient has differentiated thyroid carcinoma. Note: Examples of differentiated thyroid carcinoma include papillary, follicular, and oncocytic carcinoma (formerly Hurthle cell carcinoma), AND The disease is refractory to radioactive iodine therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	4. Acute Myeloid Leukemia: Patient has FLT3-ITD mutation-positive disease as detected by an approved test, AND Patient meets one of the following criteria (i or ii): i. This medication is used in combination with azacitidine or decitabine, OR ii. Patient has had an allogeneic stem cell transplant and is in remission. 5. Bone Cancer: Patient meets ONE of the following criteria (i or ii): i. Patient has recurrent chordoma, OR ii. Patient meets both of the following criteria (a and b): a) Patient has osteosarcoma, AND b) Patient has tried one systemic chemotherapy regimen. Note: Examples of a systemic chemotherapy regimen contain one of more of the following products: cisplastin, doxorubicin, methotrexate, or ifosfamide. 6. Gastrointestinal Stromal Tumor: Patient has previously tried each of the following (i, ii, iii, and iv): i. One of imatinib or Ayvakit (avapritinib tablets), AND ii. One of Sutent (sunitinib capsules) or Sprycel (dasatinib tablets), AND iii. Stivarga (regorafenib tablets), AND iv. Qinlock

PA Criteria	Criteria Details
	(ripretinib tablets). 7. Myeloid/Lymphoid Neoplasms with Eosinophilia: The tumor has an FLT3 rearrangement. 8. Ovarian, Fallopian Tube, Primary Peritoneal Cancer: Patient has platinum-resistant disease, AND Nexavar is used in combination with topotecan. 9. Soft Tissue Sarcoma: Patient has ONE of the following diagnoses (i, ii, or iii): i. Angiosarcoma, OR ii. Desmoid tumors (aggressive fibromatosis), OR iii. Solitary Fibrous Tumor/Hemangiopericytoma. 10. Thyroid Carcinoma, Medullary: Patient has tried at least one systemic therapy. Note: Examples of systemic therapy include: Caprelsa (vandetanib tablets), Cometriq (cabozantinib capsules), Retevmo (selpercatinib capsules), and Gavreto (pralsetinib capsules).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Acute Myeloid Leukemia. Bone Cancer. Gastrointestinal Stromal Tumor. Myeloid/Lymphoid Neoplasms with Eosinophilia. Ovarian, Fallopian Tube, Primary Peritoneal Cancer. Soft Tissue Sarcoma. Thyroid Carcinoma, Medullary.

ONCOLOGY- SPRYCEL PRIOR AUTHORIZATION POLICY

Products Affected

- SPRYCEL 100 MG TABLET
- SPRYCEL 140 MG TABLET
- SPRYCEL 20 MG TABLET
- SPRYCEL 50 MG TABLET
- SPRYCEL 70 MG TABLET
- SPRYCEL 80 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	18 years of age and older for Chondrosarcoma or Chordoma, Gastrointestinal Stromal Tumor, Myeloid/Lymphoid Neoplasms with Eosinophilia
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	A. Patient has ONE of the following: 1. Acute Lymphoblastic Leukemia 2. Chronic Myeloid Leukemia 3. Bone cancer 4. Gastrointestinal Stromal Tumor 5. Myeloid/Lymphoid Neoplasms with Eosinophilia. 6. 5. Melanoma, Cutaneous. B. Acute Lymphoblastic Leukemia: 1. Patient has Philadelphia chromosome-positive acute lymphoblastic leukemia. C. Chronic Myeloid Leukemia: 1. Patient has Philadelphia chromosome-positive chronic myeloid leukemia. D. Gastrointestinal Stromal Tumor: 1. Patient has tried imatinib or Ayvakit (avapritinib tablets). E. Myeloid/Lymphoid Neoplasms with Eosinophilia: 1. The tumor has an ABL1 rearrangement. F. Bone cancer: Patient has chondrosarcoma or chordoma. G. 5. Melanoma, Cutaneous: 1. B) Patient has metastatic or unresectable disease, AND 2. C) Patient has an activating KIT mutation, AND 3. D) Patient has tried at least one systemic regimen. Note: Examples of a systemic regimen include: Opdivo (nivolumab intravenous infusion) +

PA Criteria	Criteria Details
	Yervoy (ipilimumab intravenous infusion), Opdivo + Opdualag (nivolumab/relatlimab-rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo, Tafinlar (dabrafenib capsules) + Mekinist (trametinib tablets), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektovi (binimetinib tablets).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Chondrosarcoma or Chordoma, Gastrointestinal Stromal Tumor, Myeloid/Lymphoid Neoplasms with Eosinophilia

ONCOLOGY- SUTENT PRIOR AUTHORIZATION POLICY

Products Affected

- SUNITINIB MALATE 12.5 MG CAP
- SUNITINIB MALATE 25 MG CAPSULE
- SUNITINIB MALATE 37.5 MG CAP
- SUNITINIB MALATE 50 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Gastrointestinal Stromal Tumor: Patient meets one of the following criteria (i or ii): i. Patient has tried imatinib or Ayvakit (avapritinib tablets) OR ii. Patient has succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor. 2. Neuroendocrine Tumors of the Pancreas: Patient has advanced or metastatic disease. 3. Renal Cell Cancer: Patient meets one of the following criteria (i or ii): i. Patient has clear cell histology and meets the following criteria (a and b): a) Patient has high risk of recurrence following nephrectomy AND b) Sutent is being used as adjuvant therapy OR ii. Patient has relapsed or advanced disease. 4. Bone Cancer: Patient has recurrent chordoma. 5. Meningioma: Patient has recurrent or progressive disease. 6. Myeloid/Lymphoid Neoplasms: A) Patient has eosinophilia AND B) The tumor has an FLT3 rearrangement. 7. Pheochromocytoma/Paraganglioma: Patient has unresectable or metastatic disease. 8. Soft Tissue Sarcoma: Patient has one of the following diagnosis (i, ii, or iii): i. Alveolar soft part sarcoma OR ii. Angiosarcoma OR iii. Solitary fibrous tumor/Hemangiopericytoma. 9. Thymic Carcinoma: Patient has tried at least one systemic chemotherapy regimen. Note: Examples of a systemic chemotherapy regimen include one or more of the

PA Criteria	Criteria Details
	following products: carboplatin, paclitaxel, cisplatin, doxorubicin, cyclophosphamide, or etoposide. 10. Thyroid Carcinoma, Differentiated: A) Patient has differentiated thyroid carcinoma [Note: Examples of differentiated thyroid carcinoma include papillary, follicular, and Hurthle cell thyroid carcinoma.] AND B) Patient is refractory to radioactive iodine therapy. 11. Thyroid Carcinoma, Medullary: Patient has tried at least one systemic therapy. Note: Examples of systemic therapy include: Caprelsa (vandetanib tablets), Cometriq (cabozantinib capsules), Retevmo (selpercatinib capsules), and Gavreto (pralsetinib capsules).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Bone Cancer. Meningioma. Myeloid/Lymphoid Neoplasms. Pheochromocytoma/Paraganglioma. Soft Tissue Sarcoma. Thymic Carcinoma. Thyroid Carcinoma, Differentiated. Thyroid Carcinoma, Medullary.

ONCOLOGY- TAFINLAR PRIOR AUTHORIZATION POLICY

Products Affected

- TAFINLAR 50 MG CAPSULE
- TAFINLAR 75 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	Colon or Rectal Cancer
Required Medical Information	1. Melanoma: A) Patient is greater than or equal to 6 years of age AND B) Patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma [Note: This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery] AND C) Patient has BRAF V600 mutation-positive disease. 2. Solid Tumors Unresectable or Metastatic: [Note: Examples of solid tumors are: biliary tract cancer, brain metastases due to melanoma, high-grade gliomas, ovarian/fallopian tube/primary peritoneal cancer, differentiated thyroid carcinoma, gastrointestinal stromal tumors, gastric cancer, esophageal and esophagogastric junction cancers, salivary gland tumors, pancreatic adenocarcinoma, neuroendocrine tumors, and ampullary adenocarcinoma.] A) Patient is greater than or equal to 6 years of age AND B) Patient has BRAF V600 mutation-positive disease AND C) The medication will be taken in combination with Mekinist (trametinib tablets or oral solution) AND D) According to the prescriber, the patient has no satisfactory alternative treatment options. 3. Non-Small Cell Lung Cancer: A) Patient is greater than or equal to 6 years of age AND B) Patient has BRAF V600 mutation-positive disease. 4. Thyroid Carcinoma, Anaplastic: A) Patient is greater than or equal to 6 years of age AND B) Patient has locally advanced or metastatic anaplastic disease AND C) Patient has BRAF V600 mutation-positive disease AND D) The medication will be taken in combination with Mekinist (trametinib tablets or oral solution), unless intolerant. 5. Low Grade Glioma: A) Patient is greater than or equal to 1 year of age AND B) Patient has BRAF V600 mutation-positive disease AND C) The medication will be taken in combination with Mekinist (trametinib tablets or oral solution) AND D) Patient requires systemic therapy.
Age Restrictions	1 year of age or older

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	6. Histiocytic Neoplasm: A) Patient is greater than or equal to 6 years of age AND B) Patient meets one of the following (i or ii): i. Patient has Langerhans cell histiocytosis AND one of the following (a, b, or c): a) Multisystem disease OR b) Pulmonary disease OR c) Central nervous system lesions OR ii. Patient has Erdheim-Chester disease AND C) Patient has BRAF V600-mutation positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Histiocytic Neoplasm.

ONCOLOGY- TALZENNA PRIOR AUTHORIZATION POLICY

Products Affected

- TALZENNA 0.25 MG CAPSULE
- TALZENNA 0.5 MG CAPSULE
- TALZENNA 0.75 MG CAPSULE
- TALZENNA 1 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	Breast Cancer: Patient has recurrent or metastatic breast cancer, AND Patient has germline BRCA mutation-positive disease, AND Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- TASIGNA PRIOR AUTHORIZATION POLICY

Products Affected

- TASIGNA 150 MG CAPSULE INNER
- TASIGNA 200 MG CAPSULE INNER PACK
- TASIGNA 50 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	Acute Lymphoblastic Leukemia, Gastrointestinal Stromal Tumor, Myeloid/Lymphoid Neoplasms with Eosinophilia: 18 years of age and older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	A. Patient has ONE of the following: 1. Chronic Myeloid Leukemia 2. Acute Lymphoblastic Leukemia 3. Gastrointestinal Stromal Tumor 4. Myeloid/Lymphoid Neoplasms with Eosinophilia 5. Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor. 6. Melanoma, Cutaneous. B. Chronic Myeloid Leukemia: Patient has Philadelphia chromosome-positive chronic myeloid leukemia. C. Acute Lymphoblastic Leukemia: Patient has Philadelphia chromosome-positive acute lymphoblastic leukemia. D. Gastrointestinal Stromal Tumor: 1. Patient has tried each of the following (i, ii, iii, and iv): i. Imatinib or Ayvakit (avapritinib tablets), AND ii. Sutent (sunitinib capsules) or Sprycel (dasatinib tablets), AND iii. Stivarga (regorafinib tablets), AND iv. Qinlock (ripretinib tablets). E. Myeloid/Lymphoid Neoplasms with Eosinophilia: 1. The tumor has an ABL1 rearrangement. F. Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor: 1. Patient meets one of the following: a) Patient has tried Turalio (pexidartinib capsules), OR b) Patient cannot take Turalio, according to the prescriber. Note: Examples of reasons for not being able to take Turalio include patients with

PA Criteria	Criteria Details
	elevated liver enzymes or concomitant use of medications that are associated with hepatotoxicity. G. Melanoma, Cutaneous: a) Patient has metastatic or unresectable disease, AND b) C) Patient has an activating KIT mutation, AND c) D) Patient has tried at least one systemic regimen. Note: Examples of a systemic regimen include: Opdivo (nivolumab intravenous infusion) + Yervoy (ipilimumab intravenous infusion), Opdivo + Opdualag (nivolumab/relatlimab-rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), Opdivo, Tafinlar (dabrafenib capsules) + Mekinist (trametinib tablets), Zelboraf (vemurafenib tablets) + Cotellic (cobimetinib tablets), Braftovi (encorafenib capsules) + Mektovi (binimetinib tablets).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Acute Lymphoblastic Leukemia, Gastrointestinal Stromal Tumor, Myeloid/Lymphoid Neoplasms with Eosinophilia, Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor

ONCOLOGY- VERZENIO PRIOR AUTHORIZATION POLICY

Products Affected

- VERZENIO 100 MG TABLET
- VERZENIO 150 MG TABLET
- VERZENIO 200 MG TABLET
- VERZENIO 50 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	1. Breast Cancer (Early): A. Patient has hormone receptor positive (HR+) [such as, estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease, AND B. Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND C. Patient has node-positive disease at high risk of recurrence. Note: High risk includes patients with 4 or more positive lymph nodes, or 1-3 positive lymph nodes with one or more of the following: Grade 3 disease, tumor size greater than or equal to 5 cm, or a Ki-67 score of greater than or equal to 20%, AND D. ONE of the following criteria (i or ii): i. Will be used in combination with anastrozole, exemestane, or letrozole AND one of the following (a ,b, or c): a. Postmenopausal woman, OR b. Pre/perimenopausual woman and one of the following [(1) or (2)]: (1) Receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist. Note: Examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous injection), OR (2) Patient had surgical bilateral oophorectomy or ovarian irradiation, OR c. Patient is a man and receiving a GnRH analog. Note: Examples of a GnRH analog include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous injection), Firmagon (degarelix acetate subcutaneous injection), Orgovyx (relugolix tablet), OR ii. Will be used in combination with tamoxifen AND one of the following (a or b): a. Postmenopausal woman or man, OR b. Pre/perimenopausual woman and one of the following [(1) or (2)]: (1) Receiving ovarian suppression/ablation with a GnRH agonist, OR (2) Patient has had surgical bilateral oophorectomy or ovarian irradiation.
Age Restrictions	18 years of age and older

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	Breast Cancer - Early: 2 years. All others: 1 year
Other Criteria	2. Breast Cancer (Recurrent or Metastatic in Women): A. Recurrent or metastatic breast cancer, AND B. Patient has hormone receptor positive (HR+) [such as, estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease, AND C. Patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer, AND D. ONE of the following criteria (i or ii): i. Postmenopausal OR ii. Patient is pre/perimenopausal and one of the following (a or b): a. Receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist. Note: Examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), OR b. Patient had surgical bilateral oophorectomy or ovarian irradiation, AND E. ONE of the following criteria (i, ii, or iii): i. Will be used in combination with anastrozole, exemestane, or letrozole, OR ii. Will be used in combination with fulvestrant, OR iii. Patient meets the following conditions (a, b, and c): a. Will be used as monotherapy, AND b. Patients breast cancer has progressed on at least one prior endocrine therapy. Note: Examples of prior endocrine therapy include anastrozole, exemestane, letrozole, tamoxifen, toremifene, exemestane plus everolimus, fulvestrant, everolimus plus fulvestrant or tamoxifen, megestrol acetate, fluoxymesterone, ethinyl estradiol, AND c. Patient has tried chemotherapy for metastatic breast cancer. 3. Breast Cancer (Recurrent or Metastatic in Men): A. Recurrent or metastatic breast cancer, AND B. Patient has hormone receptor positive (HR+), AND C. Patient has HER2-negative breast cancer, AND D. ONE of the following criteria (i, ii, or iii): i. Patient meets BOTH of the following conditions (a and b): a. Patient is receiving a GnRH analog. Note: Examples of a GnRH analog include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Firmagon (degarelix acetate subcutaneous injection), Orgovyx (relugolix tablet), AND b. Verzenio will be used in combination with anastrozole, exemestane, or letrozole, OR ii. Verzenio will be used in combination with fulvestrant, OR iii. Patient meets the following conditions (a, b, and c): a. Verzenio will be used as monotherapy, AND b. Patients breast cancer has progressed on at least one prior endocrine therapy, AND c) Patient has tried chemotherapy for metastatic breast cancer. Note: A woman is defined as an individual with the biological traits of a woman, regardless of the individuals gender

PA Criteria	Criteria Details
	identity or gender expression, and men are defined as individuals with the biological traits of a man, regardless of the individuals gender identity or gender expression.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- VIZIMPRO PRIOR AUTHORIZATION POLICY

Products Affected

- VIZIMPRO 15 MG TABLET
- VIZIMPRO 30 MG TABLET
- VIZIMPRO 45 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Non-Small Cell Lung Cancer: A) Patient has advanced or metastatic disease AND B) Patient has sensitizing EGFR mutation-positive non-small cell lung cancer as detected by an approved test. [Note: Examples of sensitizing EGFR mutation-positive non-small cell lung cancer include the following: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X, and S768I.]
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- VOTRIENT PRIOR AUTHORIZATION POLICY

Products Affected

- VOTRIENT 200 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Renal Cell Cancer: A) Patient meets one of the following (i or ii): i. Patient has relapsed or advanced disease OR ii. Patient has von Hippel-Lindau disease. 2. Soft Tissue Sarcoma: A) Patient does not have gastrointestinal stromal tumor, Note: If patient has gastrointestinal stromal tumor, see criteria 4 for gastrointestinal stromal tumor, AND B) Patient has advanced or metastatic disease AND C) Patient has ONE of the following (i, ii, iii, iv, v, vi, or vii): i. Alveolar soft part sarcoma OR ii. Angiosarcoma OR iii. Desmoid tumors (aggressive fibromatosis) OR iv. Dermatofibrosarcoma protuberans with fibrosarcomatous transformation OR v. Non-adipocytic sarcoma OR vi. Pleomorphic rhabdomyosarcoma OR vii. Solitary fibrous tumor/hemangiopericytoma. 3. Bone Cancer: A) Patient has chondrosarcoma AND B) Patient meets the following (i and ii): i. Patient has metastatic disease AND ii. According to the prescriber, patient has widespread disease. 4. Gastrointestinal Stromal Tumor: A) Patient meets one of the following criteria (i or ii): i. Patient has succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor OR ii. Patient has tried each of the following (a, b, c, and d): a) One of imatinib or Ayvakit (avapritinib tablets) AND b) One of Sutent (sunitinib capsules) or Sprycel (dasatinib tablets) AND c) Stivarga (regorafinib tablets) AND d) Qinlock (ripretinib tablets). 5. Ovarian Cancer, Fallopian Tube, or Primary Peritoneal Cancer: A) Patient has persistent or recurrent disease. 6. Thyroid

PA Criteria	Criteria Details
	Carcinoma, Differentiated: A) Patient has differentiated thyroid carcinoma, Note: Examples of differentiated thyroid carcinoma include papillary, follicular, and Hurthle cell thyroid carcinoma. AND B) Patient is refractory to radioactive iodine therapy. 7. Thyroid Carcinoma, Medullary: A) Patient has tried at least one systemic therapy. Note: Examples of systemic therapy include Caprelsa (vandetanib tablets), Cometriq (cabozantinib capsules), Retevmo (selpercatinib capsules), and Gavreto (pralsetinib capsules). 8. Uterine Sarcoma, Note: Examples of uterine sarcoma include endometrial stromal sarcoma, undifferentiated uterine sarcoma, or uterine leiomyosarcomas: A) Patient has recurrent or metastatic disease AND C) Patient has tried at least one systemic regimen. Note: Examples of a systemic regimen include one or more of the following: doxorubicin, docetaxel, gemcitabine, ifosfamide, dacarbazine, epirubicin, or vinorelbine.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Bone Cancer. Gastrointestinal Stromal Tumor. Ovarian Cancer, Fallopian Tube, or Primary Peritoneal Cancer. Thyroid Carcinoma, Differentiated. Thyroid Carcinoma, Medullary. Uterine Sarcoma.

ONCOLOGY- XALKORI PRIOR AUTHORIZATION POLICY

Products Affected

- XALKORI 200 MG CAPSULE
- XALKORI 250 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	Anaplastic Large Cell Lymphoma and Inflammatory Myofibroblastic Tumor: 1 year of age or older. All other indications: 18 years of age or older.
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Anaplastic Large Cell Lymphoma: Patient has anaplastic lymphoma kinase (ALK)-positive disease, AND Patient meets one of the following criteria (i or ii): i. Patient has relapsed disease, OR ii. Patient has refractory disease. 2. Inflammatory Myofibroblastic Tumor: A) Patient has anaplastic lymphoma kinase (ALK)-positive disease, AND B) Patient meets one of the following criteria (i or ii): i. Patient has advanced, recurrent, or metastatic disease, OR ii. The tumor is inoperable. 3. Non-Small Cell Lung Cancer (Anaplastic Lymphoma Kinase [ALK])-Positive: Patient has advanced or metastatic disease, AND Patient has anaplastic lymphoma kinase (ALK)-positive disease, AND The mutation was detected by an approved test. 4. Non-Small Cell Lung Cancer, ROS1 Rearrangement-Positive: Patient has advanced or metastatic disease, AND Patient has ROS1 rearrangement-positive disease, AND The mutation was detected by an approved test. 5. Histiocytic Neoplasm: Patient has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease, AND Patient meets one of the following criteria (i, ii, or iii): i. Patient has Langerhans cell histiocytosis, OR ii. Patient had Erdheim-Chester disease, OR iii. Patient has Rosai-Dorfman disease. 6. Non-Small Cell Lung Cancer

PA Criteria	Criteria Details
	with Mesenchymal Epithelial Transition (MET) Mutation: Patient meets one of the following criteria (i or ii): i. Patient has non-small cell lung cancer with high level MET amplification, OR ii. Patient has non-small cell lung cancer with MET exon 14 skipping mutation. 7. Melanoma, Cutaneous: A) Patient meets one of the following criteria (i or ii): i. Patient has anaplastic lymphoma kinase (ALK) fusion disease OR ii. Patient has ROS1 fusion disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Histiocytic Neoplasm. Non-Small Cell Lung Cancer with Mesenchymal Epithelial Transition (MET) Mutation. Melanoma, Cutaneous.

ONCOLOGY- XPOVIO PRIOR AUTHORIZATION POLICY

Products Affected

- XPOVIO 40 MG ONCE WEEKLY DOSE OUTER
- XPOVIO 40 MG TWICE WEEKLY DOSE OUTER
- XPOVIO 60 MG TWICE WEEKLY DOSE INNER
- XPOVIO 80 MG ONCE WEEKLY DOSE OUTER

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Diffuse Large B-Cell Lymphoma. Note: This includes patients with histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma: A) Patient has been treated with at least two prior systemic therapies. 2. Multiple Myeloma: A) The medication will be taken in combination with dexamethasone AND C) Patient meets one of the following (i, ii, or iii): i. Patient has tried at least four prior regimens for multiple myeloma OR ii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma AND b) The medication will be taken in combination with bortezomib OR iii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma [Note: Examples of prior regimens include bortezomib/Revlimid (lenalidomide capsules)/dexamethasone, Kyprolis (carfilzomib intravenous infusion)/Revlimid/dexamethasone, Darzalex (daratumumab intravenous infusion)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal antibody] AND b) The medication will be taken in combination with Darzalex (daratumumab intravenous infusion), Darzalex Faspro

PA Criteria	Criteria Details
	(daratumumab and hyaluronidase-fihj subcutaneous injection), Kyprolis (carfilzomib intravenous infusion), or Pomalyst (pomalidomide capsules).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- XTANDI PRIOR AUTHORIZATION POLICY

Products Affected

- XTANDI 40 MG CAPSULE
- XTANDI 40 MG TABLET
- XTANDI 80 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Prostate Cancer - Castration-Resistant (Metastatic or Non-Metastatic): A) Patient meets ONE of the following criteria (i, ii, or iii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) agonist [Note: Examples of GnRH agonists include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant).] OR ii. The medication is concurrently used with Firmagon (degarelix subcutaneous injection) OR iii. Patient has had a bilateral orchiectomy. 2. Prostate Cancer - Metastatic, Castration-Sensitive: A) Patient meets ONE of the following criteria (i, ii, or iii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) agonist [Note: Examples of GnRH agonists include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant).] OR ii. The medication is concurrently used with Firmagon (degarelix subcutaneous injection) OR iii. Patient has had a bilateral orchiectomy.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- YONSA PRIOR AUTHORIZATION POLICY

Products Affected

- YONSA 125 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	Prostate Cancer (Metastatic, Castration-Resistant): The medication is used in combination with methylprednisolone or dexamethasone, AND Patient meets ONE of the following criteria (i, ii, or iii): i. The medication is concurrently used with a gonadotropin-releasing hormone agonist. Note: Examples of GnRH agonists include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), or Vantas (histrelin acetate subcutaneous implant), OR ii. The medication is concurrently used with Firmagon (degarelix subcutaneous injection), OR iii. Patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONCOLOGY- ZEJULA PRIOR AUTHORIZATION POLICY

Products Affected

- ZEJULA 100 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Maintenance Therapy: A) Patient is in complete or partial response after a platinum-based chemotherapy regimen. Note: Examples of chemotherapy regimens are carboplatin with gemcitabine, carboplatin with paclitaxel, cisplatin with gemcitabine AND B) Patient meets one of the following criteria (i or ii): i. Patient meets both of the following criteria (a and b): a) Patient has recurrent disease AND b) Patient has a BRCA mutation OR ii. Patient is in complete or partial response to first-line primary treatment. 2. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Treatment: A) Patient has tried at least three prior chemotherapy regimens. Note: Examples of chemotherapy regimens are carboplatin/gemcitabine, carboplatin/liposomal doxorubicin, carboplatin/paclitaxel, cisplatin/gemcitabine, capecitabine, irinotecan. AND B) Patient has homologous recombination deficiency (HRD)-positive disease as confirmed by an approved test. Note: HRD-positive disease includes patients with BRCA mutation-positive disease. 3. Uterine Leiomyosarcoma: A) Patient has a BRCA2 mutation, AND B) Patient has tried one systemic regimen. Note: Examples of a systemic regimen include one or more of the following products: dacarbazine, docetaxel, doxorubicin, epirubicin, gemcitabine, ifosfamide, vinorelbine.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Treatment. Uterine Leiomyosarcoma.

ONCOLOGY- ZELBORAF PRIOR AUTHORIZATION POLICY

Products Affected

- ZELBORAF 240 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	Central Nervous System Cancer: 3 years of age or older. Erdheim-Chester Disease,Melanoma Hairy Cell Leukemia, Histiocytic Neoplasm, Non-Small Cell Lung Cancer, Thyroid Carcinoma (Differentiated): 18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Erdheim-Chester Disease: A) Patient has BRAF V600 mutation-positive disease. 2. Melanoma: A) Patient has unresectable, advanced, or metastatic melanoma AND B) Patient has BRAF V600 mutation-positive disease. 3. Central Nervous System Cancer: A) The medication is being used for one of the following situations (i, ii, or iii): i. Adjuvant treatment of one of the following conditions (a, b, or c): a) Pilocytic astrocytoma OR b) Pleomorphic xanthoastrocytoma OR c) Ganglioglioma OR ii. Recurrent or progressive disease for one of the following conditions (a, b, c, or d): a) Glioma OR b) Isocitrate dehydrogenase-2 (IDH2)-mutant astrocytoma OR c) Oligodendroglioma OR d) Glioblastoma OR iii. Brain metastases due to melanoma AND B) Patient has BRAF V600 mutation-positive disease AND C) The medication is prescribed in combination with Cotellic (cobimetinib tablets). 4. Hairy Cell Leukemia: A) Patient has tried at least one other systemic therapy for hairy cell leukemia. Note: Examples of other systemic therapies include cladribine, Nipent (pentostatin injection), rituximab, Intron A (interferon alpha-2b injection). 5. Histiocytic Neoplasm [Note: For Erdheim-Chester disease, refer to FDA-approved indication.]: A) Patient has Langerhans cell histiocytosis and one of the

PA Criteria	Criteria Details
	following (i, ii, or iii): i. Multisystem disease OR ii. Pulmonary disease OR iii. Central nervous system lesions AND B) Patient has BRAF V600 mutation-positive disease. 6. Non-Small Cell Lung Cancer: A) Patient has BRAF V600E mutation-positive disease. 7. Thyroid Carcinoma, Differentiated: A) Patient has differentiated thyroid carcinoma [Note: Examples of differentiated thyroid carcinoma include papillary, follicular, or Hurthle cell thyroid cancers.] AND B) Patient has disease that is refractory to radioactive iodine therapy AND C) Patient has BRAF mutation-positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Central Nervous System Cancer. Hairy Cell Leukemia. Histiocytic Neoplasm. Non-Small Cell Lung Cancer. Thyroid Carcinoma, Differentiated.

ONCOLOGY- ZYKADIA PRIOR AUTHORIZATION POLICY

Products Affected

- ZYKADIA 150 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	1 year
Other Criteria	1. Non-Small Cell Lung Cancer (NSCLC)- Anaplastic Lymphoma Kinase (ALK)-Positive: A) Patient has advanced or metastatic disease, AND B) Patient has anaplastic lymphoma kinase (ALK)-positive disease, AND C) The mutation is detected by an approved test. 2. Erdheim-Chester Disease: A) Patient has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. 3. Inflammatory Myofibroblastic Tumor: A) Patient has anaplastic lymphoma kinase (ALK)-positive disease, AND B) Patient meets one of the following criteria (i or ii): i. Patient has advanced, recurrent, or metastatic disease, OR ii. The tumor is inoperable. 4. Non-Small Cell Lung Cancer with ROS1 Rearrangement: A) Patient has advanced or metastatic disease, AND B) Patient has ROS1 rearrangement-positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Erdheim-Chester Disease. Non-Small Cell Lung Cancer (NSCLC) with ROS1 Rearrangement. Inflammatory Myofibroblastic Tumor.

OXICONAZOLE NITRATE CREAM

Products Affected

- OXICONAZOLE NITRATE 1% CREAM

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	12 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of one of the following dermal infections: tinea pedis, tinea cruris, and tinea corporis due to Trichophyton rubrum, Trichophyton mentagrophytes, or Epidermophyton floccosum or tinea (pityriasis) versicolor due to Malassezia furfur AND Patient has a documented intolerance to, contraindication, or treatment failure to at least TWO of the following: clotrimazole 1% cream, econazole nitrate 1% cream, ciclopirox olamine 0.77% cream, or ketoconazole 2% cream.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OXYCODONE EXTENDED RELEASE

Products Affected

- OXYCODONE HCL ER 40 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	A. Patient has ONE of the following diagnoses: 1. Severe pain requiring an opioid analgesic (a class of drugs used to treat pain) 2. Chronic, severe pain in an opioid-tolerant patient requiring a long-term around-the-clock opioid analgesic B. The prescriber attests to patients diagnosis C. Patient meets ONE of the following: 1. Patient had a trial and inadequate clinical response (drug did not work) or intolerance (side effect) to two preferred short acting agents: oxycodone tablet, morphine sulfate tablet, oxycodone/acetaminophen, hydromorphone 2. Patient has a need for an abuse-deterrent formulation based upon a history of substance abuse (drug abuse) disorder by dissolving in order to inject or snorting 3. Patient has a need for an abuse-deterrent formulation based upon household resident having an active substance abuse disorder or a history of substance use disorder D. If the request is for Oxycodone 60mg or 80mg ER tablets, approval also requires: 1. Patient has been taking the lower strength Oxycodone ER tablets and require an increase in dose.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PALIPERIDONE

Products Affected

- INVEGA SUSTENNA 117 MG/0.75 ML
- INVEGA SUSTENNA 156 MG/ML SYRG
- INVEGA SUSTENNA 234 MG/1.5 ML
- INVEGA SUSTENNA 39 MG/0.25 ML
- INVEGA SUSTENNA 78 MG/0.5 ML

PA Criteria	Criteria Details
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 a 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 also has documented issues with compliance and long-acting injection is clinically necessary.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PALIPERIDONE TAB ER

Products Affected

- PALIPERIDONE ER 1.5 MG TABLET
- PALIPERIDONE ER 3 MG TABLET F/C
- PALIPERIDONE ER 6 MG TABLET F/C
- PALIPERIDONE ER 9 MG TABLET F/C

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PALIVIZUMAB

Products Affected

- SYNAGIS 100 MG/ML VIAL
- SYNAGIS 50 MG/0.5 ML VIAL

PA Criteria	Criteria Details
Exclusion Criteria	(1) Patient is an infant with cardiac lesions adequately corrected by surgery (unless pharmacological management is required for CHF) OR (2) Patient is an infant with chronic lung disease (CLD) not requiring medical support in the 2nd year of life OR (3) Patient is an infant with mild cardiomyopathy that does not require pharmacotherapy OR (4) Synagis will be used as routine prophylaxis for ANY of the following conditions: (4a) Down syndrome (unless qualifying heart disease, CLD/BPD, airway clearance issues or prematurity [less than 29 weeks, 0 days gestation] is present) OR (4b) Nosocomial disease prevention OR (4c) Primary asthma prevention (or for reduction of subsequent wheezing episodes) in infants and children OR (5) Synagis will be used as prophylaxis in ANY of the following scenarios: (5a) Outside of RSV season as defined by Centers for Disease and Prevention (CDC) surveillance reports or state or local health departments OR (5b) 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 OR (5c) Monthly Synagis administration as prophylaxis post breakthrough RSV hospitalization during the current season (if child had met criteria for palivizumab) OR (6) Synagis will be used for the treatment of symptomatic RSV disease.
Required Medical Information	The request is for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in a pediatric patient who meets ANY of the following: A. Request is for an early preterm infant AND patient was born before 29 weeks, 0 days gestation and is younger than 12 months of age at the start of RSV season OR B. Patient has a diagnosis of chronic lung disease of prematurity (CLD)/bronchopulmonary dysplasia (BPD) OR C. Patient has a diagnosis of hemodynamically significant congenital heart disease (CHD) OR D. Patient has a diagnosis of anatomic pulmonary abnormalities or neuromuscular disorder OR E. Request is for a patient who is immunocompromised OR F. Patient has a diagnosis of cystic fibrosis.
Age Restrictions	Less than 24 months
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	5 months
Other Criteria	A. CLD/BPD: (1) Request is for an infant younger than 12 months of age at the start of RSV season AND meets BOTH of the following: (1a) Patient is a preterm infant who developed CLD/BPD of prematurity (defined as gestational age less than 32 weeks, 0 days AND (1b) Patient requires more than 21% of oxygen for at least the first 28 days after birth) OR (2) Request for an infant between 12-24 months of age at the start of RSV season who meets ALL of the following: (2a) Patient is a preterm infant who developed CLD/BPD of prematurity (defined as gestational age less than 32 weeks, 0 days AND (2b) Patient requires more than 21% of oxygen for at least the first 28 days after birth) AND (2c) Patient continues 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. B. Hemodynamically significant congenital heart disease (CHD): Patient is an infant younger than 24 months of age at the start of RSV season with ONE of the following: (1) Patient has acyanotic heart disease and is receiving medication to control congestive heart failure (CHF) AND will require a cardiac surgical procedure OR (2) Patient has a cyanotic heart defect OR (3) Patient has moderate to severe pulmonary hypertension OR (4) Patient will undergo cardiac transplantation during RSV season. C. Anatomic pulmonary abnormalities or neuromuscular disorder: (1) Patient is an infant younger than 12 months of age at the start of RSV season AND (2) Patient has a neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough/swallow. D. Request for a patient who is immunocompromised: (1) Patient is an infant younger than 24 months of age at the start of RSV season AND (2) Patient is profoundly immunocompromised during the RSV season (Examples of severe immunodeficiencies include: severe combined immunodeficiency, severe acquired immunodeficiency syndrome, acute myeloid leukemia/acute lymphoblastic leukemia, chemotherapy, solid organ or hematopoietic stem cell transplant recipients). E. Cystic fibrosis: (1) Request is for an infant younger than 12 months of age at the start of RSV season, AND there is clinical evidence of CLD/BPD and/or nutritional compromise OR (2) Request is for an infant between 12-24 months of age at the start of RSV season who meets the following: (2a) For second year treatment, the infant has manifestations of severe lung disease including ONE of the following: (i) Previous hospitalization for pulmonary exacerbation in the first year of life OR (ii) Abnormalities on chest radiography or chest computed tomography that persist when stable OR

PA Criteria	Criteria Details
	(iii) Weight for length less than the 10th percentile on a pediatric growth chart.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PARICALCITOL

Products Affected

- PARICALCITOL 1 MCG CAPSULE
- PARICALCITOL 2 MCG CAPSULE
- PARICALCITOL 4 MCG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL/RENEWAL: Hypercalcemia, Vitamin D toxicity
Required Medical Information	INITIAL: 1. Patients intact parathyroid hormone (iPTH) levels are greater than 240 pg/mL AND 2. Corrected serum calcium less than 10.5 mg/dL AND 3. Corrected serum Ca x (times) serum phosphorus less than 70. RENEWAL: 1. Patients intact iPTH levels are greater than 120 pg/mL (or 2 times the upper limit of normal) AND 2. Corrected serum calcium less than 11.5 mg/dL AND 3. Corrected serum Ca x (times) serum phosphorus less than 75.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	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. Renewal: Patient has a diagnosis of secondary hyperparathyroidism due to chronic kidney disease (CKD).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PAROXETINE SUSPENSION

Products Affected

- PAROXETINE HCL 10 MG/5 ML SUSP

PA Criteria	Criteria Details
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	A. Patient has ONE of the following diagnoses: 1. Major depressive disorder (MDD) 2. Obsessive compulsive disorder (OCD) 3. Panic disorder (PD) 4. Social anxiety disorder (SAD) 5. Generalized anxiety disorder (GAD) 6. Posttraumatic stress disorder (PTSD) AND B. Patient has had a trial and therapeutic failure, intolerance, or contraindication to generic oral paroxetine AND C. Patient is unable to ingest solid oral dosage forms due to one of the following: (i) Oral/motor difficulties OR (ii) Dysphagia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PASIREOTIDE DIASPARTATE

Products Affected

- SIGNIFOR 0.3 MG/ML AMPULE OUTER, SUV
- SIGNIFOR 0.6 MG/ML AMPULE OUTER, SUV
- SIGNIFOR 0.9 MG/ML AMPULE OUTER, SUV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
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
Other Criteria	INITIAL: A. Patient has Cushings disease (CD: a type of hormone disorder), B. Patient has undergone pituitary (part of the brain) surgery that was not curative OR pituitary surgery is not an option, C. Patient has had trial and therapeutic failure (drug did not work), intolerance (side effect), or contraindication (harmful for) to oral ketoconazole. RENEWAL: A. Patient has Cushings disease (CD: a type of hormone disorder), B. Patient continues to have improvement of Cushings disease (such as clinically meaningful reduction in 24-hour urinary free cortisol [a type of hormone], improvements in signs and symptoms of your disease, etc.), C. Patient continues to tolerate treatment with Signifor.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PASIREOTIDE PAMOATE

Products Affected

- SIGNIFOR LAR 10 MG KIT OUTER, SUV
- SIGNIFOR LAR 20 MG KIT OUTER, SUV
- SIGNIFOR LAR 30 MG KIT OUTER, SUV
- SIGNIFOR LAR 40 MG KIT OUTER, SUV
- SIGNIFOR LAR 60 MG KIT OUTER, SUV
- SIRTURO 100 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	12 months
Other Criteria	A. ACROMEGALY: Patient has a diagnosis of acromegaly AND 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). B. CUSHINGS DISEASE: Patient has a diagnosis of Cushings disease AND Patient has had an inadequate response to surgery OR surgery is not an option.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PCSK9

Products Affected

- REPATHA 140 MG/ML SURECLICK P/F, SUV
- REPATHA 140 MG/ML SYRINGE P/F, SUV
- REPATHA 420 MG/3.5 ML PUSHTRONX P/F, SUV

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	INITIAL: Documented diagnosis of HeFH confirmed by ONE Simon Broome criteria listed below: Prescriber reports TC greater than 290mg/dL or greater than 260mg/dL in patients less than 16 years of age, OR LDL cholesterol greater than 190mg/dL or greater than 155mg/dL in patients less than 16 years of age, AND Documentation of a history of tendon xanthomas in ONE of the following: the patient, AND/OR patients first degree relative, AND/OR patients second degree relative, OR Documentation of ONE of the following: Family history of myocardial infarction in a first degree relative less than 60 years of age, AND/OR Family history of myocardial infarction in a second degree relative less than 50 years of age, AND/OR Family history of LDL-C greater than 190mg/dL in a first or second degree relative, OR Documentation of a history of arcus cornealis before age of 45 in ONE of the following: the patient, AND/OR first of second degree relative, AND HeFH diagnosis confirmed by genetic testing of an LDL receptor mutation, familiar defective apoB, or a PCSK9 mutation. HoFH: Diagnosis of HoFH confirmed by clinical diagnosis based on ANY one the following: Patient has a documented history of untreated LDL-C greater than 400 mg/dL AND 1 or both parents having clinical diagnosed familial hypercholesterolemia, or documented treatment for LDL-C greater than 300mg/dL, OR Prescriber attests to genetic evidence of an LDL receptor mutation, familial defective apo B-100, or a PCSK9 mutation or autosomal recessive FH, OR LDL-C greater than 400mg/dL with aortic valve disease, OR LDL-C greater than 400mg/dL with xanthomata at less than 20 years of age. CLINICAL ASCVD OR PRIMARY HYPERLIPIDEMIA AT HIGH RISK FOR ASCVD: Prescriber reports: baseline and current LDL-C, AND One of the following: baseline LDL-C is between 70-189mg/dL, OR patient requires greater than 25 percent additional lowering of LDL-C.
Age Restrictions	REPATHA: CVD: 18 years of age or older, HeFH and HoFH: 10 years of age or older.

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	INITIAL: 12 months, RENEWAL: 12 months
Other Criteria	INITIAL: A. HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH): Prescriber attests that PCSK-9 will be used in combination with a maximally tolerated statin OR prescriber attests that patient is statin intolerant and can provide rationale to intolerance or contraindication. B. 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. C. CLINICAL ASCVD OR PRIMARY HYPERLIPIDEMIA AT HIGH RISK FOR ASCVD: (1) Patient has a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) OR primary hyperlipidemia at high risk for ASCVD, AND (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, OR (b) myocardial infarction (MI), OR (c) coronary or other arterial revascularization, OR (d) stroke, OR (e) transient ischemic stroke (TIA), OR (f) stable/unstable angina, OR (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, 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

PA Criteria	Criteria Details
	myositis or myalgia related symptoms with either, rosuvastatin, atorvastatin OR another maximally tolerated statin
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

Products Affected

- ALYQ 20 MG TABLET
- SILDENAFIL 20 MG TABLET
- TADALAFIL 20 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	INITIAL: Documented confirmatory PAH diagnosis based on right heart catheterization
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PEGFILGRASTIM

Products Affected

- FULPHILA 6 MG/0.6 ML SYRINGE
- ZIEXTENZO 6 MG/0.6 ML SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

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

Products Affected

- PEGASYS 180 MCG/0.5 ML SYRINGE
- PEGASYS 180 MCG/ML VIAL RTU,SDV

PA Criteria	Criteria Details
Exclusion Criteria	Pegasys- HEPATITIS B: Cirrhosis
Required Medical Information	Pegasys- HEPATITIS B: (1) Serum HBeAg positive chronic hepatitis B, AND (2) Documented evidence of viral replication with elevated serum ALT. HEPATITIS C: Documented detectable pretreatment HCV RNA level/viral load (Varies by lab assay but is a level typically greater than or equal to 25 IU/mL)
Age Restrictions	Pegasys- HEPATITIS B: 3 years of age or older, HEPATITIS C: 5 years of age or older. PegIntron: 3 years of age or older
Prescriber Restrictions	HEPATITIS B: Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, a physician specializing in the treatment of hepatitis (e.g., a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model. HEPATITS C: Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, or a physician specializing in the treatment of hepatitis (e.g., a hepatologist)
Coverage Duration	Pegasys- HEP B: 24wks, HEP C: G2, 4: tot of 24wks G1, 3, 5, 6: tot-48wks PegIntron- HEP C: 48wks
Other Criteria	Pegasys- HEPATITIS C: (1) Use as a part of a combination antiviral treatment regimen. PegIntron- INITIAL: HEPATITIS C: (1) compensated liver disease, AND (2) Use as a part of a combination antiviral treatment regimen. RENEWAL: HEPATITIS C: (1) Use as a part of a combination antiviral treatment regimen
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PEGVISOMANT

Products Affected

- SOMAVERT 10 MG VIAL OUTER,SUV
- SOMAVERT 15 MG VIAL SDV
- SOMAVERT 20 MG VIAL SDV,OUTER
- SOMAVERT 25 MG VIAL SDV,OUTER
- SOMAVERT 30 MG VIAL SDV,OUTER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	ACROMEGALY (INITIAL): Prescriber must provide the following baseline documentation from patients medical record: (i) Elevated serum IGF-1 level for patients age range and gender AND (ii) Elevated growth hormone level defined by a GH level greater than or equal to 1 ng/mL during oral glucose tolerance test (OGTT). ACROMEGALY (RENEWAL):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	N/A
Coverage Duration	INITIAL/RENEWAL: 12 months
Other Criteria	ACROMEGALY INITIAL/RENEWAL: Patient has a diagnosis of Acromegaly. ACROMEGALY (INITIAL): Patient has had an inadequate response to surgery or radiation therapy, or documentation that these therapies are not appropriate.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PENICILLAMINE

Products Affected

- PENICILLAMINE 250 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
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	N/A
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.
Other Criteria	INITIAL: WILSONS DISEASE:(1) Maintained a low copper diet (less than 2 mg copper per day). 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 alkalization. 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. RENEWAL:RA:1) No history of or other evidence of renal

PA Criteria	Criteria Details
	insufficiency 2) Experienced or maintained improvement in tender joint count or swollen joint count while on therapy compared to baseline.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PENTOSAN POLYSULFATE

Products Affected

- ELMIRON 100 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	INITIAL: 6 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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PERAMPANEL

Products Affected

- FYCOMPA 10 MG TABLET
- FYCOMPA 12 MG TABLET
- FYCOMPA 2 MG TABLET
- FYCOMPA 4 MG TABLET
- FYCOMPA 6 MG TABLET
- FYCOMPA 8 MG TABLET

PA Criteria	Criteria Details
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	A. Patient has a diagnosis of partial-onset seizures AND patient has had a trial and failure, intolerance, or contraindication to at least TWO (2) antiepileptic drugs OR has a history of Vagal Nerve Stimulator (VNS) implantation or lobectomy OR B. 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHENOXYBENZAMINE

Products Affected

- PHENOXYBENZAMINE HCL 10 MG CAP

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, an endocrine surgeon, or a hematologist/oncologist
Coverage Duration	21 days
Other Criteria	(1) Requested for treatment of pheochromocytoma prior to pheochromocytoma resection/removal. (2) Trial of or contraindication to an alpha-1 selective adrenergic receptor blocker (such as doxazosin, terazosin, or prazosin).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHOSPHATE BINDERS

Products Affected

- LANTHANUM CARB 1,000 MG TB CHW OUTER
- LANTHANUM CARB 500 MG TAB CHEW INNER
- LANTHANUM CARB 750 MG TAB CHEW INNER
- SEVELAMER 0.8 GM POWDER PACKET OUTER
- SEVELAMER 2.4 GM POWDER PACKET OUTER
- SEVELAMER HCL 400 MG TABLET
- SEVELAMER HCL 800 MG TABLET

PA Criteria	Criteria Details
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	A. For sevelamer carbonate powder packet/sevelamer HCL: 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. B. 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PIMECROLIMUS

Products Affected

- PIMECROLIMUS 1% CREAM

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PIRFENIDONE

Products Affected

- PIRFENIDONE 267 MG CAPSULE
- PIRFENIDONE 267 MG TABLET
- PIRFENIDONE 801 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	INITIAL: (1) Documentation showing 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) Documentation showing 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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PLECANATIDE

Products Affected

- TRULANCE 3 MG TABLET

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

POSACONAZOLE

Products Affected

- POSACONAZOLE DR 100 MG TABLET

PA Criteria	Criteria Details
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, AND documentation showing that the diagnosis 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: 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	6 months
Other Criteria	A. TREATMENT OF INVASIVE ASPERGILLUS: Patient has had a trial and therapeutic failure of voriconazole AND amphotericin B. B. PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTIONS: (1) Patient is recipient of hematopoietic stem cell transplant (HSCT) with Graft-vs-Host Disease (GVHD) and who is at risk of developing invasive Aspergillus fumigatus and/or Candida infections, OR (2) Patient has hematological malignancies causing prolonged neutropenia from chemotherapy and who is at risk of developing Aspergillus fumigatus and/or Candida infections.
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A

PRAMLINTIDE

Products Affected

- SYMLINPEN 120 PEN INJECTOR SUV
- SYMLINPEN 60 PEN INJECTOR SUV

PA Criteria	Criteria Details
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	A. Patient has type 1 or type 2 diabetes AND B. Patient utilizes both basal and short-acting insulin OR uses an insulin pump AND C. Patient has failed to achieve desired glucose control despite optimal insulin therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PRASTERONE

Products Affected

- INTRAROSA 6.5 MG VAG INSERT

PA Criteria	Criteria Details
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
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 a diagnosis of moderate to severe dyspareunia AND 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PRAZIQUANTEL

Products Affected

- PRAZIQUANTEL 600 MG TABLET

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

PROCARBAZINE

Products Affected

- MATULANE 50 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	Patients with inadequate marrow reserve as demonstrated by bone marrow aspiration.
Required Medical Information	N/A
Age Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PROGESTERONE

Products Affected

- CRINONE 4% GEL OUTER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	None
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Crinone 4%: Patient's prescriber attests that patient has secondary amenorrhea, AND Patient had a clinical trial and therapeutic failure of at least ONE alternative progestin (such as medroxyprogesterone, norethindrone) unless contraindicated or clinically significant adverse effects were experienced. Crinone 8%: A. The request is for ONE of the following: 1. Luteal phase support (that is, patient has a history of unexpected pregnancy loss before the 20th week) 2. Secondary amenorrhea 3. Prevention of preterm birth (birth that occurs before the 37th week of pregnancy) B. For luteal phase support: Patient's prescriber attests the request is for luteal phase support, C. For secondary amenorrhea: Patient's prescriber attests that patient has a diagnosis of secondary amenorrhea, AND Patient had a clinical trial and therapeutic failure of at least ONE alternative progestin unless contraindicated or clinically significant adverse effects were experienced, D. For prevention of preterm birth: Patient's prescriber attests (confirms) the request is for prevention of preterm birth, AND There is documentation showing patient has a short cervix OR a singleton pregnancy AND a history of spontaneous preterm birth. Renewal Crinone 4%: A. Patient has secondary amenorrhea, B. Patient has previously met initial approval criteria, C. Patient's prescriber attests that patient has a positive response to therapy. Renewal Crinone 8%: A. The request is for ONE of the following: 1. Luteal phase support 2. Secondary amenorrhea 3. Prevention of preterm birth, B. Patient has previously met

PA Criteria	Criteria Details
	initial approval criteria C. Patient's prescriber attests that patient has a positive response to therapy
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Prevention of preterm birth. Luteal phase support (i.e., history of spontaneous abortions)

PYRAZINAMIDE

Products Affected

- PYRAZINAMIDE 500 MG TABLET

PA Criteria	Criteria Details
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 antituberculosis agents OR patient had a treatment failure with other primary drugs for active tuberculosis AND prescribed dosing and duration are within the current CDC and American Thoracic Society guidelines
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PYRIDOSTIGMINE

Products Affected

- PYRIDOSTIGMINE 60 MG/5 ML SOLN

PA Criteria	Criteria Details
Exclusion Criteria	Mechanical intestinal or urinary obstruction
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PYRIMETHAMINE

Products Affected

- PYRIMETHAMINE 25 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Patients with documented megaloblastic anemia due to folate deficiency.
Required Medical Information	TOXOPLASMOSIS 1. PRIMARY PROPHYLAXIS FOR TOXOPLASMIC ENCEPHALITIS: (1a) patient is Toxoplasma IgG positive AND (1b) Patient has a documented CD4 less than or equal to 100 cells/mm3 if initiating prophylaxis OR CD4 less than 100-200 cells/mm3 if reinstituting prophylaxis. (Note: Chart notes/medical records required for documentation).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PRIMARY PROPHYLAXIS:6 mo. TX (TOXOPLASMOSIS), SECONDARY PROPHYLAXIS (TOXOPLASMOSIS, PCP):12 mo
Other Criteria	TOXOPLASMOSIS: Patient has documentation confirming the use of pyrimethamine is supported for patient's diagnosis of (1) Active severe acquired toxoplasmosis (including toxoplasmic encephalitis and congenital toxoplasmosis) OR (2) Secondary prophylaxis of toxoplasmic encephalitis OR (3) Primary prophylaxis for toxoplasmic encephalitis AND (3a) Pyrimethamine will be used in combination with dapsone or atovaquone AND (3b) Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP- SMX) AND (3c) Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate OR (3d) Patient has experienced a moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g. toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome) and is contraindicated for a re-challenge. PNEUMOCYSTIS PNEUMONIA (PCP): (1a) Pyrimethamine is being used as primary Pneumocystis Pneumonia (PCP) prophylaxis in an HIV infected patient OR (1b) Pyrimethamine is being used as secondary prophylaxis in an HIV infected patient who has been treated for an acute episode of Pneumocystis Pneumonia AND (2) Patient has experienced intolerance to prior

PA Criteria	Criteria Details
	prophylaxis with trimethoprim-sulfamethoxazole (TMP- SMX) AND (3a) Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate OR (3b) Patient has experienced a moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g. toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome) and is contraindicated for a re-challenge. (Note: Chart notes/medical records required for documentation).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Toxoplasmosis (primary and secondary prophylaxis). Pneumocystis Pneumonia (primary and secondary prophylaxis).

RANOLAZINE

Products Affected

- RANOLAZINE ER 1,000 MG TABLET
- RANOLAZINE ER 500 MG TABLET

PA Criteria	Criteria Details
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 or 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 documented trial and therapeutic failure, intolerance, or contraindication to ALL of the following at maximum tolerated dosages: calcium channel blocker, beta-blocker, nitrate. (Note: Patient chart notes, medical records, or electronic claim history required for documentation).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RETAPAMULIN

Products Affected

- ALTABAX 1% OINTMENT

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	9 months of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of impetigo, AND the impetigo is due to susceptible isolates of Staphylococcus aureus and Streptococcus pyogenes, AND Patient has a documented adequate trial and therapeutic failure, intolerance, or contraindication to mupirocin 2% ointment
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RIFABUTIN

Products Affected

- RIFABUTIN 150 MG CAPSULE

PA Criteria	Criteria Details
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	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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RIFAXIMIN

Products Affected

- XIFAXAN 200 MG TABLET F/C
- XIFAXAN 550 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	N/A
Age Restrictions	HE: Xifaxan 550mg: 18 years of age or older, IBS WITH DIARRHEA: 18 years of age or older, TRAVELERS DIARRHEA: 12 years of age or older.
Prescriber Restrictions	HE: Prescribed by or in consultation with a hepatologist, IBS WITH DIARRHEA: Prescribed by or in consultation with a gastroenterologist, CDI: Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	INITIAL:HE:550mg:12mos, 200mg:10days IBS:12wks TRVLRS DIARR:3days C.DIFF:20days RENEW:HE, IBS:12mos
Other Criteria	INITIAL: HE: 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. IBS WITH DIARRHEA: (1) Trial 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. CDI: (1) Had at least one previous occurrence of Clostridium difficile infection, AND (2) Use in combination with vancomycin. RENEWAL - HE: Request is for Xifaxan 550mg tablets. IBS WITH DIARRHEA: 1) At least 6 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.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off-Label Uses	Xifaxan 200mg: Hepatic encephalopathy (HE) treatment, Clostridium difficile infection (CDI)

RILONACEPT

Products Affected

- ARCALYST 220 MG VIAL

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	CAPS/FCAS/MWS/Pericarditis: 12 years of age or older. Deficiency of interleukin-1 receptor antagonist (DIRA): 18 years of age or older OR weighs at least 10kg.
Prescriber Restrictions	Initial: (CAPS, FCAS, MWS, DIRA): Prescribed by, or in consultation with, a rheumatologist or immunologist. (RP): Prescribed by, or in consultation with, a rheumatologist, immunologist, or cardiologist.
Coverage Duration	12 months
Other Criteria	A. Patient has ONE of the following diagnoses: 1. Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-Inflammatory Syndrome or Muckle-Wells Syndrome OR 2. Deficiency of interleukin-1 receptor antagonist (DIRA) OR 3. Recurrent pericarditis AND B. If patient has deficiency of interleukin-1 receptor antagonist (DIRA), approval also requires: Arcalyst will be used for maintenance of remission.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RIOCIGUAT

Products Affected

- ADEMPAS 0.5 MG TABLET
- ADEMPAS 1 MG TABLET
- ADEMPAS 1.5 MG TABLET
- ADEMPAS 2 MG TABLET
- ADEMPAS 2.5 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH) WHO GROUP I: INITIAL: Documented confirmatory pulmonary arterial hypertension diagnosis based on right heart catheterization. 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
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ROLAPITANT

Products Affected

- VARUBI 180 MG DOSE(2X 90 MG TB)

PA Criteria	Criteria Details
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 or older
Prescriber Restrictions	None
Coverage Duration	6 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. (HEC/MEC list: Highly Emetogenic Chemotherapy (HEC): Carboplatin, Carmustine, Cisplatin, Cyclophosphamide, Dacarbazine, Doxorubicin, Epirubicin, Ifosfamide, Mechlorethamine, Streptozocin. Moderately Emetogenic Chemotherapy (MEC): 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)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ROTIGOTINE

Products Affected

- NEUPRO 1 MG/24 HR PATCH
- NEUPRO 2 MG/24 HR PATCH
- NEUPRO 3 MG/24 HR PATCH
- NEUPRO 4 MG/24 HR PATCH
- NEUPRO 6 MG/24 HR PATCH
- NEUPRO 8 MG/24 HR PATCH

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has a diagnosis of Parkinsons disease OR Restless leg syndrome AND meets one of the following criteria: (1) Patient had a trial and therapeutic failure, intolerance, or contraindication to generic oral pramipexole AND oral ropinirole OR (2) Patient is unable to ingest solid oral dosage forms due to ONE of the following: (2a) Oral/motor difficulties OR (2b) Dysphagia.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SANTYL

Products Affected

- SANTYL OINTMENT

PA Criteria	Criteria Details
Exclusion Criteria	Known hypersensitivity to collagenase
Required Medical Information	Documented presence of wound including size, location, and tissue content
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a wound care specialist, infectious disease specialist, or dermatologist
Coverage Duration	2 months
Other Criteria	Renewal: 1. Documentation of wound improvement AND 2. Documentation that wound debridement is incomplete
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SELEXIPAG

Products Affected

- UPTRAVI 1,000 MCG TABLET
- UPTRAVI 1,200 MCG TABLET
- UPTRAVI 1,400 MCG TABLET
- UPTRAVI 1,600 MCG TABLET
- UPTRAVI 200 MCG TABLET
- UPTRAVI 200-800 TITRATION PACK
- UPTRAVI 400 MCG TABLET
- UPTRAVI 600 MCG TABLET
- UPTRAVI 800 MCG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	INITIAL: (1) Documented confirmatory pulmonary arterial hypertension diagnosis based on right heart catheterization (2) NYHA-WHO Functional Class II-IV symptoms.
Age Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SERTACONAZOLE NITRATE

Products Affected

- ERTACZO 2% CREAM

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

SILODOSIN

Products Affected

- SILODOSIN 4 MG CAPSULE
- SILODOSIN 8 MG CAPSULE

PA Criteria	Criteria Details
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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SIROLIMUS

Products Affected

- SIROLIMUS 0.5 MG TABLET
- SIROLIMUS 1 MG TABLET
- SIROLIMUS 1 MG/ML SOLUTION
- SIROLIMUS 2 MG TABLET

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOFOSBUVIR/VELPATASVIR

Products Affected

- EPCLUSA 150-37.5 MG PELLET PKT OUTER
- EPCLUSA 200 MG-50 MG TABLET
- EPCLUSA 200-50 MG PELLET PACK OUTER
- EPCLUSA 400 MG-100 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	(1) Patient is currently taking any of the following medications: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, efavirenz-containing HIV (human immunodeficiency virus) regimens, rosuvastatin at doses above 10mg, tipranavir/ritonavir, topotecan, sofosbuvir (Sovaldi) (as a single agent), ledipasvir/sofosbuvir (Harvoni), elbasvir/grazoprevir (Zepatier), pibrentasvir/glecaprevir (Mavyret), or velpatasvir/sofosbuvir/voxilaprevir (Vosevi). (2) Patient has a limited life expectancy (less than 12 months) due to non-liver related comorbid conditions (e.g., physician attestation)
Required Medical Information	Documentation showing patient has a chronic HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months (Note: Chart notes or lab reports required for documentation)
Age Restrictions	3 years of age older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (for example, a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model
Coverage Duration	12 weeks
Other Criteria	If patient has a diagnosis of chronic hepatitis C, genotype 1, 2, 3, 4, 5, or 6 WITH decompensated cirrhosis (symptoms related to liver damage), approval also requires that the requested medication will be used with ribavirin. If patient does not have cirrhosis (liver damage) OR has compensated cirrhosis (a condition where liver is extensively scarred, but does not have symptoms of liver damage), approval also requires that patient meets ONE of the following: (1) Treatment naive and genotype 1-6 infection OR (2) Treatment experienced, genotype 1-6 infection, with prior treatment with ONE of the following: (a) peginterferon/ribavirin OR (b) NS3 protease inhibitor triple therapy (Olysio, Incivek or Victrelis with

PA Criteria	Criteria Details
	peginterferon/ribavirin) OR (3) Treatment experienced, genotype 1b or genotype 2 infection, with previous treatment with Sovaldi (sofosbuvir)-containing regimen (e.g., Sovaldi/ribavirin with or without peginterferon or Sovaldi/Olysio) that does not include an NS5A inhibitor.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI 400-100-100 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	(1) Patient is currently taking any of the following medications: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, efavirenz-containing HIV (human immunodeficiency virus) regimens, rosuvastatin at doses above 10mg, tipranavir/ritonavir, topotecan, sofosbuvir (Sovaldi) (as a single agent), ledipasvir/sofosbuvir (Harvoni), elbasvir/grazoprevir (Zepatier), pibrentasvir/glecaprevir (Mavyret), or velpatasvir/sofosbuvir/voxilaprevir (Vosevi). (2) Patient has moderate or severe hepatic impairment (Child-Pugh B or C). (3) Patient has a limited life expectancy (less than 12 months) due to non-liver related comorbid conditions (e.g., physician attestation)
Required Medical Information	Documentation showing patient has a chronic HCV infection documented by at least ONE detectable HCV RNA level within the last 6 months (Note: Chart notes or lab reports required for documentation)
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (for example, a hepatologist), or a specially trained group such as ECHO (Extension for Community Healthcare Outcomes) model
Coverage Duration	12 weeks
Other Criteria	Genotype 1-6: treatment experienced and previously failed a full course of therapy with DAA regimen that includes NS5A inhibitor (e.g., Harvoni, Epclusa, Technivie, Viekira Pak or Viekira XR, Zepatier, or Daklinza/Sovaldi combination). Genotype 1a or 3: treatment experienced and previously failed a full course of therapy with DAA regimen that includes sofosbuvir without NS5A inhibitor (e.g., Sovaldi/ribavirin, Sovaldi/peginterferon/ribavirin, Olysio/Sovaldi (or other HCV protease inhibitor in combination with Sovaldi))
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOLRIAMFETOL

Products Affected

- SUNOSI 150 MG TABLET
- SUNOSI 75 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, psychiatrist, or specialist in sleep medicine
Coverage Duration	INITIAL: 6 months. RENEWAL: 12 months.
Other Criteria	EXCESSIVE DAYTIME SLEEPINESS (EDS) WITH NARCOLEPSY: INITIAL: (1) Narcolepsy is confirmed by ONE of the following: a) Multiple Sleep Latency Test (MSLT) showing both a mean sleep latency of 8 minutes or less AND 2 or more early-onset rapid eye movement (REM) sleep test periods (SOREMPs), OR b) Multiple Sleep Latency Test (MSLT) showing both a mean sleep latency of 8 minutes or less AND one early-onset rapid eye movement (REM) sleep test period (SOREMP) AND additionally one SOREMP (within approximately 15 minutes) on a polysomnography the night preceding the MSLT, with the polysomnography ruling out non-narcolepsy causes of excessive daytime sleepiness (EDS), OR c) Low orexin (aka hypocretin) levels on a cerebrospinal fluid (CSF) assay. (2) Excessive Daytime Sleepiness (EDS) persisting for at least 3 months and Epworth Sleepiness Scale (ESS) score of more than 10. (3) Trial of or contraindication to one amphetamine derivative (e.g., amphetamine sulfate, methylphenidate, etc.) AND modafinil or armodafinil. RENEWAL: Demonstrated 25% or more improvement in Epworth Sleepiness Scale (ESS) scores compared to baseline. EXCESSIVE DAYTIME SLEEPINESS (EDS) WITH OBSTRUCTIVE SLEEP APNEA (OSA):INITIAL: (1) OSA confirmed by ONE of the following: a) polysomnography, OR b) home sleep apnea testing devices, OR c) hospital-based bedside monitoring. (2) Excessive

PA Criteria	Criteria Details
	Daytime Sleepiness (EDS) persisting for at least 3 months and Epworth Sleepiness Scale (ESS) score of more than 10. (3) Trial of or contraindication to modafinil or armodafinil. (4) Receiving ongoing treatment to address the obstructive causes of OSA, for at least one month since initiation, and has been counseled on weight-loss intervention (if BMI greater than 30). RENEWAL: Demonstrated 25% or more improvement in Epworth Sleepiness Scale (ESS) scores compared to baseline.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOMATROPIN

Products Affected

- NORDITROPIN FLEXPRO 10 MG/1.5
- NORDITROPIN FLEXPRO 15 MG/1.5
- NORDITROPIN FLEXPRO 30 MG/3 ML
- NORDITROPIN FLEXPRO 5 MG/1.5

PA Criteria	Criteria Details
Exclusion Criteria	Prescribed for athletic enhancement, anti-aging purposes, or idiopathic short stature.
Required Medical Information	PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD): (1) Documentation showing 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): (1) Documentation showing 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.
Age Restrictions	N/A
Prescriber Restrictions	INIT/RNWL: PEDIATRIC GHD, TURNER SYN, NOONAN SYN, PRADER-WILLI SYN, SMALL GESTATIONAL AGE, ADULT GHD: Prescribed by/in consultation with endocrinologist
Coverage Duration	12 mo
Other Criteria	PEDIATRIC GHD: (1) Epiphyses NOT closed. (2) ONE from: a) Annual growth velocity greater than 2 cm, OR b) Annual growth velocity greater than 1 cm for patients near terminal phase of puberty. TURNER SYN, SMALL GESTATIONAL AGE, NOONAN SYNDROME: (1) Epiphyses NOT closed. (2) Growth velocity of greater than 2 cm or patient hasnt

PA Criteria	Criteria Details
	reached 50th percent of predicted adult ht. PRADER-WILLI SYN: (1) Improvement in body composition.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SUCRALFATE

Products Affected

- SUCRALFATE 1 GM/10 ML SUSP

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to sucralfate.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	3 months
Other Criteria	Patient has a diagnosis of active duodenal ulcer AND meets BOTH of the following criteria: (1) Patient had a trial and therapeutic failure, intolerance, or contraindication to generic oral sucralfate tablet AND (2) Request is for short-term (up to 8 weeks) therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SULCONAZOLE NITRATE

Products Affected

- EXELDERM 1% CREAM
- EXELDERM 1% SOLUTION
- SULCONAZOLE NITRATE 1% CREAM
- SULCONAZOLE NITRATE 1% SOLN

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of Tinea pedis (athletes foot) (Topical solution only)
Required Medical Information	N/A
Age Restrictions	18 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	1 month.
Other Criteria	EXELDERM 1% EXTERNAL SOLUTION: Patient has a diagnosis of ONE of the following: a. Tinea cruris, b. Tinea corporis, c. Tinea versicolor AND patient has experienced an inadequate treatment response, intolerance, or contraindication to TWO generic formulary alternatives indicated to treat tinea cruris, tinea corporis, and/or tinea versicolor (e.g. clotrimazole, ketoconazole, miconazole, naftifine) AND if the patient has tinea cruris or tinea corporis, it is caused by Trichophyton rubrum, Trichophyton mentagrophytes, Epidermophyton floccosum, or Microsporum canis. EXELDERM 1% EXTERNAL CREAM: Patient has a diagnosis of ONE of the following: a. Tinea cruris, b. Tinea corporis, c. Tinea pedis, d. Tinea versicolor AND patient has experienced an inadequate treatment response, intolerance, or contraindication to TWO generic formulary alternatives indicated to treat tinea cruris, tinea corporis, tinea pedis, and/or tinea versicolor (e.g. clotrimazole, ketoconazole, miconazole, naftifine) AND if the patient has tinea pedis, tinea cruris, or tinea corporis, it is caused by Trichophyton rubrum, Trichophyton mentagrophytes, Epidermophyton floccosum, or Microsporum canis.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

SUMATRIPTAN

Products Affected

- SUMATRIPTAN 20 MG NASAL SPRAY
- SUMATRIPTAN 5 MG NASAL SPRAY
- SUMATRIPTAN 6 MG/0.5 ML AUTOINJ SDV, OUTER
- SUMATRIPTAN 6 MG/0.5 ML AUTOINJ SUV
- SUMATRIPTAN 6 MG/0.5 ML VIAL INNER,SDV

PA Criteria	Criteria Details
Exclusion Criteria	Prevention of migraine or cluster headache attacks, 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. Nasal Spray: treatment of cluster headache
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	A. Patient has a diagnosis or indication for ONE of the following: 1. Acute treatment of migraines 2. Acute treatment of cluster headaches AND B. If the medication is being used for the acute treatment of migraines, approval also requires the following: 1. Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to ALL of the following

PA Criteria	Criteria Details
	(medication usage must be supported by documentation from the patients chart notes/medical records electronic claim history): oral sumatriptan, rizatriptan, naratriptan, almotriptan AND 2. For sumatriptan injection: Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to Sumatriptan Nasal Spray (before injection).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TADALAFIL

Products Affected

- TADALAFIL 2.5 MG TABLET INNER
- TADALAFIL 5 MG TABLET INNER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	ED: Patient has erectile dysfunction and has tried generic sildenafil (Viagra) BPH: A. Patient has benign prostatic hyperplasia (BPH) B. Patient has tried at least two preferred formulary alternatives, including one medication from each of the following classes: 1. 5-alpha-reductase inhibitors (such as finasteride or dutasteride) 2. Alpha blockers (such as doxazosin, terazosin, tamsulosin, or alfuzosin)
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAZAROTENE

Products Affected

- TAZAROTENE 0.05% GEL
- TAZAROTENE 0.1% GEL

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy. Use on more than 20% body surface area.
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	A. ACNE VULGARIS: (1) Patient has a diagnosis of mild to moderate facial acne vulgaris AND (2) Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to topical tretinoin. B. PLAQUE PSORIASIS: (1) Patient has a diagnosis of plaque psoriasis AND (2) Patient has had a documented trial and therapeutic failure, contraindication, or intolerance to at least TWO (2) topical corticosteroids (e.g., clobetasol, fluocinonide, mometasone, triamcinolone).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEDIZOLID

Products Affected

- SIVEXTRO 200 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age and older.
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	1 week
Other Criteria	Documentation of patients trial and therapeutic failure to other antibiotics to which the organism is susceptible. Note: Susceptible isolates (bacteria causing the disease) of the following gram-positive microorganisms are: Staphylococcus aureus (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA] isolates), Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus Group (including Streptococcus anginosus, Streptococcus intermedius, and Streptococcus constellatus), and Enterococcus faecalis.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEMOZOLOMIDE-PO

Products Affected

- TEMOZOLOMIDE 100 MG CAPSULE
- TEMOZOLOMIDE 140 MG CAPSULE
- TEMOZOLOMIDE 180 MG CAPSULE
- TEMOZOLOMIDE 20 MG CAPSULE
- TEMOZOLOMIDE 250 MG CAPSULE
- TEMOZOLOMIDE 5 MG CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	A. Patient has one of the following diagnoses: 1. Refractory anaplastic astrocytoma. 2. Glioblastoma multiforme OR 3. Metastatic melanoma. B. If the diagnosis is refractory anaplastic astrocytoma, patient has experienced disease progression on a drug regimen containing nitrosourea and procarbazine. C. If the diagnosis is glioblastoma multiforme, the requested medication is being used at the same time as radiotherapy for a newly diagnosed patient then being used as a maintenance therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Metastatic Melanoma.

TENOFOVIR ALAFENAMIDE

Products Affected

- VEMLIDY 25 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	N/A
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 positive and HBV DNA greater 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 1.5 times ULN, total bilirubin less than 2.5 times 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.
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TESTOSTERONE

Products Affected

- TESTOSTERON ENAN 1,000 MG/5 ML MDV
- TESTOSTERONE 1% (25 MG/2.5 G) PK OUTER
- TESTOSTERONE 1.62% (2.5 G) PKT INNER
- TESTOSTERONE 1.62% GEL PUMP
- TESTOSTERONE 1.62%(1.25 G) PKT OUTER

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	INITIAL: MALE HYPOGONADISM: Documented 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	N/A
Coverage Duration	MALE HYPOGONADISM, GENDER DYSPHORIA:12mos. DELAYED PUBERTY (MALES), FEMALE W/BREAST CANCER: Lifetime
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. 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.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Gender dysphoria as supported by the compendia (e.g., DrugDex strength of recommendation Class I, IIa, or IIb)

TETRABENAZINE

Products Affected

- TETRABENAZINE 12.5 MG TABLET
- TETRABENAZINE 25 MG TABLET

PA Criteria	Criteria Details
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	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist that treats Huntingtons Disease.
Coverage Duration	INITIAL/RENEWAL: 3 months
Other Criteria	Diagnosis of chorea associated with Huntingtons Disease 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEZACAFTOR/IVACAFTOR

Products Affected

- SYMDEKO 100/150 MG-150 MG TABS
- SYMDEKO 50/75 MG-75 MG TABLETS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
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.
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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

THIOGUANINE

Products Affected

- TABLOID 40 MG TABLET

PA Criteria	Criteria Details
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	Patient has a diagnosis of acute nonlymphocytic leukemias.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOBRAMYCIN INHALED

Products Affected

- TOBRAMYCIN 300 MG/5 ML AMPULE P/F

PA Criteria	Criteria Details
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	N/A
Coverage Duration	12 months.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOLCAPONE

Products Affected

- TOLCAPONE 100 MG TABLET

PA Criteria	Criteria Details
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
Other Criteria	INITIAL: Patient has a diagnosis of Parkinsons disease AND 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: Patient has a diagnosis of Parkinsons disease AND 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOPICAL RETINOIDS

Products Affected

- TRETINOIN 0.05% CREAM
- TRETINOIN 0.1% CREAM

PA Criteria	Criteria Details
Exclusion Criteria	Request is for a cosmetic condition.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	The medication being requested for a Medical condition (that is, a NON-COSMETIC condition). (Note: Examples of Medical conditions (that is, non-cosmetic conditions) include acanthosis nigricans, acne rosacea, actinic keratosis/precancerous lesions, alopecia areata, basal cell carcinoma (skin cancer), diabetic foot ulcers, dysplasia of cervix, folliculitis (for example, pseudofolliculitis barbae), ichthyosis (e.g., congenital, lamellar, vulgaris, X-linked), keloid scars, keratosis (e.g., keratosis follicularis [Dariers disease], keratosis pilaris), lichen planus, lichen sclerosis, military osteoma cutis, molluscum contagiosum, mucositis, oral leukoplakia, papillomatosis, systemic sclerosis, and warts.
Indications	Some FDA-approved Indications Only.
Off-Label Uses	N/A

TOREMIFENE

Products Affected

- TOREMIFENE CITRATE 60 MG TAB

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TREPROSTINIL

Products Affected

- ORENITRAM ER 0.125 MG TABLET
- ORENITRAM ER 0.25 MG TABLET
- ORENITRAM ER 1 MG TABLET
- ORENITRAM ER 2.5 MG TABLET
- ORENITRAM ER 5 MG TABLET
- ORENITRAM MONTH 1 TITRATION KT
- ORENITRAM MONTH 2 TITRATION KT
- ORENITRAM MONTH 3 TITRATION KT

PA Criteria	Criteria Details
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.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or given in consultation with a cardiologist or pulmonologist
Coverage Duration	12 months
Other Criteria	INITIAL: 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 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), 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 - ORENITRAM: One of the following:(1) Patient had improvement from baseline in the 6-minute walk distance test OR (2) Patient remained stable

PA Criteria	Criteria Details
	from baseline in the 6-minute walk distance test AND the patients World Health Organization (WHO) functional class has improved or remained stable.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRETINOIN ORAL

Products Affected

- TRETINOIN 10 MG CAPSULE

PA Criteria	Criteria Details
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/RARa 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.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRIAMCINOLONE AEROSOL

Products Affected

- TRIAMCINOLONE 0.147 MG/G SPRAY

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	A. Patient has corticosteroid-responsive dermatoses, AND B. 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% solution.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRIFLURIDINE EYE DROPS

Products Affected

- TRIFLURIDINE 1% EYE DROPS

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	21 Days
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VALGANCICLOVIR

Products Affected

- VALGANCICLOVIR 450 MG TABLET
- VALGANCICLOVIR HCL 50 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to valganciclovir or ganciclovir.
Required Medical Information	PREVENTION OF CMV DISEASE: Donor CMV seropositive/Recipient CMV seronegative [D+/R-]
Age Restrictions	For prevention of CMV disease: 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	A. Patient has ONE of the following diagnoses: 1. Cytomegalovirus (CMV) Retinitis OR 2. Prevention of CMV Disease in patients with a kidney, heart, and kidney-pancreas transplant AND B. If the request is for oral solution, patient meets ONE of the following criteria: 1. Patient has had a trial and failure, intolerance, or contraindication to oral valganciclovir tablets OR 2. Patient is unable to ingest solid oral dosage forms (e.g., dysphagia, etc.) AND C. If patient has CYTOMEGALOVIRUS (CMV) RETINITIS: Patient has a documented diagnosis of Cytomegalovirus (CMV) Retinitis AND patient has a documented diagnosis of acquired immunodeficiency syndrome (AIDS) OR D. If medication is being used for PREVENTION OF CMV DISEASE: Valcyte is being used for the prevention of CMV Disease in patients with a kidney, heart, and kidney-pancreas transplant at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-]) AND patient meets ONE of the following criteria: 1. Patient is post kidney transplant and is 4 months of age or older OR 2. Patient is post heart transplant and is 1 month of age or older OR 3. Patient is post kidney-pancreas transplant.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VILAZODONE

Products Affected

- VIIBRYD 10 MG TABLET
- VIIBRYD 10-20 MG STARTER PACK
- VIIBRYD 20 MG TABLET
- VIIBRYD 40 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Patients taking, or within 14 days of stopping, monoamine oxidase inhibitors (MAOIs), including MAOIs such as linezolid or intravenous methylene blue.
Required Medical Information	None
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Major depressive disorder (MDD): (1) Patient has a diagnosis of MDD AND (2) Documentation of patients 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
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VORICONAZOLE

Products Affected

- VORICONAZOLE 200 MG TABLET F/C
- VORICONAZOLE 40 MG/ML SUSP
- VORICONAZOLE 50 MG TABLET F/C

PA Criteria	Criteria Details
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	A. The request is for ONE of the following: 1. Invasive aspergillus OR 2. Candidemia in a non-neutropenic patient OR 3. One of the following Candida infections: disseminated infection in skin or infection in abdomen, kidney, bladder wall, or wound OR 4. Esophageal candidiasis OR 5. A serious fungal infection caused by Scedosporium apiospermum (asexual form of Pseudallescheria boydii) or Fusarium species including Fusarium solani AND B. If patient has invasive aspergillus, approval also requires: 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. AND C. For ALL other indications, approval also requires: 1. Patient had a trial and failure, contraindication, or intolerance to fluconazole.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZILEUTON

Products Affected

- ZILEUTON ER 600 MG TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Use in the reversal of bronchospasm in acute asthma attacks. Patients with active liver disease or persistent hepatic function enzyme elevations greater than or equal to 3 times the upper limit of normal (≥3 times ULN). Patients with a history of allergic reaction to zileuton.
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has diagnosis of Asthma AND meets all of the following: (1) Documentation of patients trial and therapeutic failure, intolerance, or contraindication to ALL of the following: montelukast and zafirlukast AND (2) Request is for the prophylaxis and chronic treatment of asthma. (Note: Chart notes or medical records required for documentation).
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

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