



# **VNS Health EasyCare (HMO)**

## **Prior Authorization Requirements**

**Effective: 03/01/2023**

# ABALOPARATIDE

---

## Products Affected

- TYMLOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>POSTMENOPAUSAL OSTEOPOROSIS: ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S), B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE, (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE), (3) TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO ONE BISPHOSPHONATE. PATIENT HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ABATACEPT IV

## Products Affected

- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
<b>Coverage Duration</b>	RA, PJIA, PSA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. AGVHD: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ, RINVOQ, SKYRIZI. RENEWAL: RA, PJIA, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ABATACEPT SQ

## Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ, RINVOQ, SKYRIZI. RENEWAL: RA, PJIA, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ABEMACICLIB

---

## Products Affected

- VERZENIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# ABIRATERONE

---

## Products Affected

- *abiraterone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC HIGH-RISK CASTRATION-SENSITIVE PROSTATE CANCER, METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ABIRATERONE SUBMICRONIZED

---

## Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ACALABRUTINIB

---

## Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ADAGRASIB

---

## Products Affected

- KRAZATI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ADALIMUMAB

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPHTHALMOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA, PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIEN E, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. RENEWAL: RA, PJIA, PSA, AS, PSO, HIDRADENITIS SUPPURATIVA, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AFATINIB

---

## Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	METASTATIC NSCLC WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ALECTINIB

---

## Products Affected

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# ALPELISIB

---

## Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# AMBRISENTAN

## Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: 1) DOCUMENTED CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) OF 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	PAH: INITIAL: PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS. RENEWAL: 1) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE, OR 2) A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AMIVANTAMAB-VMJW

---

## Products Affected

- RYBREVANT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# APALUTAMIDE

## Products Affected

- ERLEADA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): TRIAL OF OR CONTRAINDICATION TO XTANDI OR ABIRATERONE. NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): (1) HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS), AND (2) TRIAL OF OR CONTRAINDICATION TO XTANDI OR NUBEQA. NMCRPC, MCSPC: (1) RECEIVED A BILATERAL ORCHIECTOMY, (2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR (3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE ANALOG. RENEWAL: DIAGNOSIS OF NMCRPC OR MCSPC.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# APOMORPHINE

---

## Products Affected

- *apomorphine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	PD: INITIAL: PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PD. RENEWAL: IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WHILE ON THERAPY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# APOMORPHINE - SL

---

## Products Affected

- KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	PD: INITIAL: PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PARKINSONS DISEASE. RENEWAL: IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF KYNMOBI.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# APREMILAST

## Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: MILD PLAQUE PSORIASIS (PSO): ONE OF THE FOLLOWING: 1) PSORIASIS COVERING 2 PERCENT OF BODY SURFACE AREA (BSA), 2) STATIC PHYSICIAN GLOBAL ASSESSMENT (SPGA) SCORE OF 2, OR 3) PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 2 TO 9. MODERATE TO SEVERE PSO: 1) PSORIASIS COVERING 3 PERCENT OR MORE OF BSA, OR 2) PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ, RINVOQ, SKYRIZI. MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC AGENT (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) AND ONE CONVENTIONAL TOPICAL AGENT (E.G., PUVA, UVB, TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI, TREMFYA. BEHCETS DISEASE: 1) PATIENT HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). RENEWAL: PSA, PSO, BEHCETS DISEASE: CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# ASCIMINIB

---

## Products Affected

- SCEMBLIX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML); MUTATIONAL ANALYSIS PRIOR TO INITIATION AND SCEMBLIX IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ASFOTASE

---

## Products Affected

- STRENSIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HYPOPHOSPHATASIA (HPP): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST, GENETICIST, OR METABOLIC SPECIALIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: PERINATAL/INFANTILE-ONSET HPP: 1) 6 MONTHS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC CHEST DEFORMITY, (II) CRANIOSYNOSTOSIS, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV) HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, (V) NEPHROCALCINOSIS OR HISTORY OF ELEVATED SERUM CALCIUM, (VI) HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. JUVENILE-ONSET HPP: 1) 18 YEARS OF AGE OR YOUNGER AT ONSET OF HPP, AND 2) POSITIVE FOR A TNSALP ALPL GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR TWO OF THE FOLLOWING: (A) SERUM ALP LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE, (B) ELEVATED SERUM PLP LEVELS AND NO VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK, (C) URINE PEA LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE, (D) RADIOGRAPHIC EVIDENCE OF HPP, (E) AT LEAST TWO OF THE FOLLOWING: (I) RACHITIC DEFORMITIES, (II) PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, (III) DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, (IV)</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. ALL INDICATIONS: 1) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE, 2) CALCIUM OR PHOSPHATE LEVELS ARE NOT BELOW THE NORMAL RANGE, 3) NOT HAVE A TREATABLE FORM OF RICKETS. RENEWAL: ALL INDICATIONS: 1) IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HPP, AND 2) NOT CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ATOGEPANT

---

## Products Affected

- QULIPTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	EPISODIC MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AVAPRITINIB

---

## Products Affected

- AYVAKIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AVATROMBOPAG

## Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC LIVER DISEASE (CLD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, ENDOCRINOLOGIST, OR A SURGEON. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	CLD: 1 MONTH. CHRONIC ITP: INITIAL: 2 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: CLD: 1) PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET, AND 2) NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G., ROMIPLOSTIM, ELTROMBOPAG, ETC.). CHRONIC ITP: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS OR INSUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: CHRONIC ITP: PATIENT HAD A CLINICAL RESPONSE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# AXITINIB

---

## Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# AZACITIDINE

---

## Products Affected

- ONUREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# AZTREONAM

---

## Products Affected

- CAYSTON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	7 YEARS OF AGE OR OLDER
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BARICITINIB

---

## Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS, SEVERE ALOPECIA AREATA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# BEDAQUILINE

---

## Products Affected

- SIRTURO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 WEEKS
<b>Other Criteria</b>	PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS (MDR-TB): SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MDR-TB.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BELIMUMAB

---

## Products Affected

- BENLYSTA SUBCUTANEOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. LUPUS NEPHRITIS (LN): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PATIENT HAD CLINICAL IMPROVEMENT. LN: IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BELUMOSUDIL

---

## Products Affected

- REZUROCK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BELZUTIFAN

---

## Products Affected

- WELIREG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BENDAMUSTINE

---

## Products Affected

- *bendamustine intravenous recon soln*
- BENDEKA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# BENRALIZUMAB

---

## Products Affected

- FASENRA
- FASENRA PEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
<b>Coverage Duration</b>	INITIAL: 4 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. RENEWAL: 1) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS 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.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BETAINE

---

## Products Affected

- *betaine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BEVACIZUMAB-AWWB

---

## Products Affected

- MVASI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BEVACIZUMAB-BVZR

---

## Products Affected

- ZIRABEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# BEXAROTENE

---

## Products Affected

- *bexarotene*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BINIMETINIB

---

## Products Affected

- MEKTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BORTEZOMIB

---

## Products Affected

- *bortezomib injection recon soln 1 mg, 2.5 mg* • VELCADE
- BORTEZOMIB INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# BOSENTAN

## Products Affected

- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: 1) DOCUMENTED CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) OF 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p>PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.</p>
<b>Coverage Duration</b>	<p>INITIAL/RENEWAL: 12 MONTHS.</p>
<b>Other Criteria</b>	<p>PAH: INITIAL: 1) DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASE IN BILIRUBIN BY 2 OR MORE TIMES ULN, AND 2) NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: 1) NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE, 2) AGES 3 TO 17 YEARS OF AGE: A) DEMONSTRATED IMPROVEMENT IN PVR, OR B) REMAINED STABLE OR SHOWN IMPROVEMENT IN EXERCISE ABILITY, 3) AGES 18 YEARS OR OLDER: A) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE, OR B) A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BOSUTINIB

---

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUSLY TREATED (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND BOSULIF IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# BRIGATINIB

---

## Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# C1 ESTERASE INHIBITOR-CINRYZE

## Products Affected

- CINRYZE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# C1 ESTERASE INHIBITOR-HAEGARDA

## Products Affected

- HAEGARDA SUBCUTANEOUS  
RECON SOLN 2,000 UNIT, 3,000 UNIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CABOZANTINIB

---

## Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CABOZANTINIB S-MALATE - CABOMETYX

---

## Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# CANNABIDIOL

---

## Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: LENNOX-GASTAUT SYNDROME (LGS): TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM. RENEWAL: DS, LGS, TSC: CONFIRMATION OF DIAGNOSIS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# CAPLACIZUMAB YHDP

## Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACQUIRED THROMBOTIC THROMBOCYTOPENIA PURPURA (ATTP): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	ATTP: CABLIVI WAS PREVIOUSLY INITIATED AS PART OF THE FDA APPROVED TREATMENT REGIMEN IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY WITHIN AN INPATIENT SETTING. THE PATIENT HAS NOT EXPERIENCED MORE THAN TWO RECURRENCES OF ATTP WHILE ON CABLIVI THERAPY (I.E., NEW DROP IN PLATELET COUNT REQUIRING REPEAT PLASMA EXCHANGE DURING 30 DAYS POST-PLASMA EXCHANGE THERAPY [PEX] AND UP TO 28 DAYS OF EXTENDED THERAPY).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# CAPMATINIB

---

## Products Affected

- TABRECTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CARGLUMIC ACID

## Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: ACUTE, CHRONIC HYPERAMMONEMIA (HA) DUE TO N ACETYLGLUTAMATE SYNTHASE (NAGS) DEFICIENCY: NAGS GENE MUTATION IS CONFIRMED BY BIOCHEMICAL OR GENETIC TESTING. ACUTE HA DUE TO PROPIONIC ACIDEMIA (PA): 1) CONFIRMED BY THE PRESENCE OF ELEVATED METHYLCITRIC ACID AND NORMAL METHYLMALONIC ACID, OR 2) GENETIC TESTING CONFIRMING MUTATION IN THE PCCA OR PCCB GENE. ACUTE HA DUE TO METHYLMALONIC ACIDEMIA (MMA): 1) CONFIRMED BY THE PRESENCE OF ELEVATED METHYLMALONIC ACID, METHYLCITRIC ACID, OR 2) GENETIC TESTING CONFIRMING MUTATION IN THE MMUT, MMA, MMAB OR MMADHC GENES.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ACUTE HA DUE TO NAGS/PA/MMA: 7 DAYS. CHRONIC HA DUE TO NAGS: INITIAL: 6 MOS, RENEWAL: 12 MOS.
<b>Other Criteria</b>	RENEWAL: CHRONIC HA DUE TO NAGS: PATIENT HAS SHOWN CLINICAL IMPROVEMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CERITINIB

---

## Products Affected

- ZYKADIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CERTOLIZUMAB PEGOL

## Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ, RINVOQ, SKYRIZI. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI, TREMFYA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, SKYRIZI. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, RINVOQ. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS. RENEWAL: RA, PSA, AS, PSO, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CETUXIMAB

---

## Products Affected

- ERBITUX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# CLADRIBINE

## Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 48 WEEKS.
Other Criteria	MS: INITIAL: HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF 2 CYCLES IN EACH). RENEWAL: 1) HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE, 2) DOES NOT HAVE LYMPHOPENIA, AND 3) HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF 2 CYCLES IN EACH).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# CLOBAZAM-SYMPAZAN

---

## Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	LGS: 1) PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION, AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY CLOBAZAM AGENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# COBIMETINIB

---

## Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# COLCHICINE

---

## Products Affected

- *colchicine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PROPHYLAXIS OF GOUT FLARES: 16 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PROPHYLAXIS OF GOUT FLARES: TRIAL OF OR CONTRAINDICATION TO COLCHICINE CAPSULES (MITIGARE) IF AGE 18 YEARS OR OLDER.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# CORTICOTROPIN

## Products Affected

- ACTHAR
- CORTROPHIN GEL

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. OTHER FDA APPROVED INDICATIONS: INITIAL AND RENEWAL: 28 DAYS
Other Criteria	INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: TRIAL OF OR CONTRAINDICATION TO A STANDARD OF CARE THERAPY. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: 1) DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS, AND 2) CONTINUES TO POSSESS CONTRAINDICATION TO IV CORTICOSTEROIDS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN.
Indications	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CRIZOTINIB

---

## Products Affected

- XALKORI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# CYSTEAMINE HYDROCHLORIDE

---

## Products Affected

- CYSTARAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# DABRAFENIB

---

## Products Affected

- TAFINLAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DACOMITINIB

---

## Products Affected

- VIZIMPRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	METASTATIC NSCLC: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DALFAMPRIDINE

---

## Products Affected

- *dalfampridine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	MULTIPLE SCLEROSIS (MS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
<b>Coverage Duration</b>	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	MS: INITIAL: HAS SYMPTOMS OF A WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA. RENEWAL: IMPROVEMENT IN WALKING ABILITY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DAROLUTAMIDE

---

## Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS.
Other Criteria	<p>INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): PATIENT HAS HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC): 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: NMCRPC: NO ADDITIONAL CRITERIA REQUIRED. MHSPC: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DASATINIB

---

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUSLY TREATED Ph+ CML: MUTATIONAL ANALYSIS PRIOR TO INITIATION AND SPRYCEL IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DECITABINE/CEDAZURIDINE

---

## Products Affected

- INQOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DEFERASIROX

## Products Affected

- *deferasirox*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT): 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) AND 2) LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NTDT: 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR 2) LIC OF 3 MG FE/G DRY WEIGHT OR GREATER.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: CHRONIC IRON OVERLOAD: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL FOR ALL INDICATIONS: FORMULARY VERSION OF DEFERASIROX SPRINKLE: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX TABLET OR TABLET FOR ORAL SUSPENSION.
<b>Indications</b>	All FDA-approved Indications.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DEFERIPRONE

## Products Affected

- *deferiprone*
- FERRIPROX (2 TIMES A DAY)
- FERRIPROX ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TRANSFUSIONAL IRON OVERLOAD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROMES: 1) TRIAL OF, CONTRAINDICATION, INTOLERABLE TOXICITIES, OR CLINICALLY SIGNIFICANT ADVERSE EFFECTS TO ONE OF THE FOLLOWING: FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE, OR 2) CURRENT CHELATION THERAPY (I.E., FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE) IS INADEQUATE. TRANSFUSIONAL IRON OVERLOAD DUE TO SICKLE CELL DISEASE OR OTHER ANEMIAS: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE. RENEWAL (ALL INDICATIONS): SERUM FERRITIN LEVELS CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS).
Indications	All FDA-approved Indications.
Off Label Uses	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# DENOSUMAB-XGEVA

---

## Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DEUTETRABENAZINE

---

## Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	TARDIVE DYSKINESIA: PATIENT HAS A HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# DICLOFENAC GEL

---

## Products Affected

- *diclofenac sodium topical gel 3%*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DICLOFENAC TOPICAL SOLUTION

---

## Products Affected

- *diclofenac sodium topical solution in metered-dose pump*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	OSTEOARTHRITIS OF THE KNEE: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1% TOPICAL GEL AND A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# DIMETHYL FUMARATE

---

## Products Affected

- *dimethyl fumarate oral capsule, delayed release(dr/lec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# DIROXIMEL FUMARATE

---

## Products Affected

- VUMERITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DOSTARLIMAB-GXLY

---

## Products Affected

- JEMPERLI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DRONABINOL

---

## Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL OF OR CONTRAINDICATION TO ONE ANTIEMETIC THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D FOR THE INDICATION OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# DROXIDOPA

## Products Affected

- *droxidopa*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH): INITIAL: 1) BASELINE BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE POSITION. 2) A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NOH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
<b>Coverage Duration</b>	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
<b>Other Criteria</b>	NOH: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DUPILUMAB

## Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC ESOPHAGITIS (EOE): DIAGNOSIS CONFIRMED BY ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH BIOPSY.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: AD, PN: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST.
<b>Coverage Duration</b>	INITIAL: AD, CRSWNP, EOE, PN: 6 MOS, ASTHMA: 4 MOS. RENEWAL: ALL INDICATIONS: 12 MOS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: AD: 1) AD COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR AD AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS, 2) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 3) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID, CALCINEURIN INHIBITOR, PDE4 INHIBITOR, OR JAK INHIBITOR), AND 4) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR AD. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND ONE OTHER MAINTENANCE MEDICATION, 2) ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS, OR ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NO CONCURRENT USE WITH XOLAIR OR OTHER ANTI-IL5 BIOLOGICS WHEN USED FOR ASTHMA. CRSWNP: 1) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY, AND 3) A 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. PN: 1) CHRONIC PRURITIS (ITCH MORE</p>

PA Criteria	Criteria Details
	<p>THAN 6 WEEKS), MULTIPLE PRURIGINOUS LESIONS, AND HISTORY OR SIGN OF A PROLONGED SCRATCHING BEHAVIOR, 2) TRIAL OF OR CONTRAINDICATION TO ONE TOPICAL (CORTICOSTEROID OR CALCIPOTRIOL). RENEWAL: AD: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR AD. CRSWNP, EOE: IMPROVEMENT WHILE ON THERAPY. ASTHMA: 1) NO CONCURRENT USE WITH XOLAIR, OR OTHER ANTI-IL5 BIOLOGICS FOR ASTHMA, 2) CONTINUED USE OF ICS AND ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY: (A) REDUCTION IN ASTHMA EXACERBATIONS 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. PN: IMPROVEMENT OR REDUCTION OF PRURITIS OR PRURIGINOUS LESIONS.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# DUVELISIB

---

## Products Affected

- COPIKTRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# ELAGOLIX SODIUM

## Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
<b>Age Restrictions</b>	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 18 YEARS OF AGE OR OLDER.
<b>Prescriber Restrictions</b>	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
<b>Coverage Duration</b>	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 2) TRIAL OF OR CONTRAINDICATION TO A NSAID AND PROGESTIN-CONTAINING PREPARATION. RENEWAL: 1) IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# ELEXACAFITOR-TEZACAFITOR-IVACAFITOR

## Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	CYSTIC FIBROSIS (CF); INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
<b>Other Criteria</b>	CF: RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ELIGLUSTAT

---

## Products Affected

- CERDELGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ELTROMBOPAG

## Products Affected

- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	ITP: INITIAL: 2 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO.
Other Criteria	INITIAL: PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA PURPURA (ITP): TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ALL INDICATIONS: APPROVAL FOR PROMACTA ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF PROMACTA TABLETS OR PATIENT IS UNABLE TO TAKE TABLET FORMULATION. RENEWAL: ITP: PATIENT HAS SHOWN A CLINICAL RESPONSE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# EMAPALUMAB-LZSG

## Products Affected

- GAMIFANT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS (HLH): INITIAL: 1) A GENETIC TEST IDENTIFYING HLH-ASSOCIATED GENE MUTATION (E.G., PRF1, UNC13D), OR 2) HAS AT LEAST FIVE OF THE FOLLOWING EIGHT DIAGNOSTIC CRITERIA FOR HLH: (A) FEVER, (B) SPLENOMEGALY, (C) CYTOPENIAS (AFFECTING AT LEAST 2 OF 3 CELL LINEAGES), (D) HYPERTRIGLYCERIDEMIA OR HYPOFIBRINOGENEMIA, (E) HEMOPHAGOCYTOSIS IN BONE MARROW OR SPLEEN OR LYMPH NODES AND NO EVIDENCE OF MALIGNANCY, (F) LOW OR ABSENT NATURAL KILLER-CELL ACTIVITY, (G) FERRITIN LEVEL OF 500 MCG/L OR GREATER, (H) SOLUBLE CD25 LEVEL OF 2,400 U/ML OR GREATER.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HLH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN IMMUNOLOGIST, HEMATOLOGIST, OR ONCOLOGIST.
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 8 WEEKS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	HLH: INITIAL: 1) CONCURRENT THERAPY WITH DEXAMETHASONE, AND 2) ONE OF THE FOLLOWING: (A) HAS REFRACTORY, RECURRENT, OR PROGRESSIVE DISEASE, OR (B) HAD A TRIAL OF OR INTOLERANCE TO CONVENTIONAL HLH THERAPY (I.E., CHEMOTHERAPY, STEROIDS, IMMUNOTHERAPY). RENEWAL: 1) HAS NOT RECEIVED SUCCESSFUL HEMATOPOIETIC STEM CELL TRANSPLANTATION, AND 2) DEMONSTRATED IMPROVED IMMUNE SYSTEM RESPONSE FROM BASELINE (E.G., RESOLUTION OF FEVER, DECREASED SPLENOMEGALY, IMPROVEMENT IN CNS SYMPTOMS, IMPROVED CBC, INCREASED FIBRINOGEN LEVELS, REDUCED D-DIMER, REDUCED FERRITIN, REDUCED SOLUBLE CD25 LEVELS.)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ENASIDENIB

---

## Products Affected

- IDHIFA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# ENCORAFENIB

---

## Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ENTRECTINIB

---

## Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ENZALUTAMIDE

---

## Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: CASTRATION-RESISTANT PROSTATE CANCER (CRPC) THAT IS NOT METASTATIC: PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: DIAGNOSIS OF CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR MCSPC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# EPOETIN ALFA-EPBX

## Products Affected

- RETACRIT INJECTION SOLUTION  
10,000 UNIT/ML, 2,000 UNIT/ML,  
20,000 UNIT/2 ML, 20,000 UNIT/ML,  
3,000 UNIT/ML, 4,000 UNIT/ML, 40,000  
UNIT/ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CKD: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. CANCER CHEMOTHERAPY: 1) HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL, OR 2) THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<p>ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH.</p>
<b>Other Criteria</b>	<p>RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ERDAFITINIB

---

## Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ERLOTINIB

---

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NSCLC WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ESKETAMINE

---

## Products Affected

- SPRAVATO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: TREATMENT-RESISTANT DEPRESSION (TRD), MAJOR DEPRESSIVE DISORDER (MDD): PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	INITIAL: TRD: 3 MONTHS. MDD: 4 WEEKS. RENEWAL: TRD, MDD: 12 MONTHS.
Other Criteria	INITIAL: TRD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, 2) NO ACTIVE SUBSTANCE ABUSE, AND 3) ADEQUATE TRIAL (AT LEAST 4 WEEKS) OF AT LEAST TWO ANTIDEPRESSANT AGENTS FROM DIFFERENT CLASSES THAT ARE INDICATED FOR DEPRESSION. MDD: 1) NON-PSYCHOTIC, UNIPOLAR DEPRESSION, AND 2) NO ACTIVE SUBSTANCE ABUSE. RENEWAL: TRD, MDD: DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# ETANERCEPT

---

## Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
<b>Age Restrictions</b>	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), PSORIATIC ARTHRITIS (PSA): 18 YEARS OR OLDER.
<b>Prescriber Restrictions</b>	INITIAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE: IS REQUIRED. PJIA, PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. RENEWAL: RA, PJIA, PSA, AS, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# EVEROLIMUS

---

## Products Affected

- *everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus (antineoplastic) oral tablet for suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF SUNITINIB OR SORAFENIB.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# FEDRATINIB

---

## Products Affected

- INREBIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	MYELOFIBROSIS: INITIAL: TRIAL OF OR CONTRAINDICATION TO JAKAFI (RUXOLITINIB). RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FENFLURAMINE

## Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME (LGS): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	DRAVET SYNDROME: INITIAL/RENEWAL: 12 MONTHS. LGS: 12 MONTHS.
Other Criteria	INITIAL: LGS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM. RENEWAL: DRAVET SYNDROME: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# FENTANYL CITRATE

---

## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: 1) CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR PATIENT HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# FILGRASTIM-AAFI

---

## Products Affected

- NIVESTYM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FILGRASTIM-AYOW

---

## Products Affected

- RELEUKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NIVESTYM, WHERE INDICATIONS ALIGN.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# FILGRASTIM-SNDZ

---

## Products Affected

- ZARXIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: NIVESTYM.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FINERENONE

---

## Products Affected

- KERENDIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FINGOLIMOD

---

## Products Affected

- *fingolimod*
- GILENYA ORAL CAPSULE 0.25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# FINGOLIMOD LAURYL SULFATE

---

## Products Affected

- TASCENSO ODT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	MULTIPLE SCLEROSIS (MS): (1) UNABLE TO SWALLOW FINGOLIMOD CAPSULES, AND (2) TRIAL OF OR CONTRAINDICATION TO FINGOLIMOD CAPSULES.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# FREMANEZUMAB-VFRM

---

## Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# FUTIBATINIB

---

## Products Affected

- LYTGOBI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INTRAHEPATIC CHOLANGIOCARCINOMA (ICCA): COMPLETE A COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# GALCANEZUMAB-GNLM

## Products Affected

- EMGALITY PEN 3)
- EMGALITY SYRINGE  
SUBCUTANEOUS SYRINGE 120  
MG/ML, 300 MG/3 ML (100 MG/ML X

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINE PREVENTION: 6 MOS. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): 12 MOS.
Other Criteria	INITIAL: MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: MIGRAINE PREVENTION: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. EPISODIC CLUSTER HEADACHE: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# GANAXOLONE

---

## Products Affected

- ZTALMY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# GEFITINIB

---

## Products Affected

- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC NSCLC WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# GILTERITINIB

---

## Products Affected

- XOSPATA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# GLASDEGIB

---

## Products Affected

- DAURISMO ORAL TABLET 100 MG,  
25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# GLATIRAMER

---

## Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# GLYCEROL PHENYL BUTYRATE

---

## Products Affected

- RAVICTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	UREA CYCLE DISORDER (UCD): INITIAL: DIAGNOSIS IS CONFIRMED BY ENZYMATIC, BIOCHEMICAL OR GENETIC TESTING
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	UCD: INITIAL: TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYL BUTYRATE. RENEWAL: PATIENT HAS CLINICAL BENEFIT FROM BASELINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# GOSERELIN

## Products Affected

- ZOLADEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
<b>Coverage Duration</b>	STAGE B2-C PROSTATIC CARCINOMA: 4 MOS. ENDOMETRIOSIS: 6 MOS PER LIFETIME. ALL OTHERS: 12 MONTHS.
<b>Other Criteria</b>	ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# GUSELKUMAB

## Products Affected

- TREMFYA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PSO: TRIAL OF OR CONTRAINDICATION ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

## Products Affected

- *morphine concentrate oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OPIOID TOLERANT: 12 MONTHS. HOSPICE, PALLIATIVE CARE OR END OF LIFE CARE: LIFETIME.
Other Criteria	1) OPIOID TOLERANT (I.E. PREVIOUS USE OF 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, 60 MG ORAL HYDROCODONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID) AND HAS TROUBLE SWALLOWING OPIOID TABLETS, CAPSULES, OR LARGE VOLUMES OF LIQUID, OR 2) ENROLLED IN HOSPICE OR PALLIATIVE CARE OR END OF LIFE CARE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

## Products Affected

- *promethazine injection solution* mg
- *promethazine oral*
- *promethazine rectal*
- *promethegan rectal suppository 12.5 mg, 25*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE OR PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - SCOPOLAMINE

---

## Products Affected

- *scopolamine base*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

---

## Products Affected

- *ascomp with codeine*
- *butalbital-acetaminophen-caff oral tablet*
- *butalbital-aspirin-caffeine*
- *codeine-butalbital-asa-caff*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

---

## Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK DRUGS IN THE ELDERLY - DISOPYRAMIDE

---

## Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

## Products Affected

- *amabelz*
- *dotti*
- DUAVEE
- *estradiol oral*
- *estradiol transdermal patch semiweekly*
- *estradiol transdermal patch weekly*
- *estradiol-norethindrone acet oral tablet 0.5-0.1 mg*
- *fyavolv*
- *jinteli*
- *lyllana*
- *mimvey*
- *norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg*
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT PREVIOUSLY MENTIONED IN THIS SECTION, SUCH AS PALLIATIVE TREATMENT, AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No



# HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - SULFONYLUREAS

---

## Products Affected

- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF GLIMEPIRIDE, GLIPIZIDE, OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

---

## Products Affected

- *ketorolac oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 DAYS
<b>Other Criteria</b>	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

---

## Products Affected

- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *methocarbamol oral tablet 500 mg, 750 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK DRUGS IN THE ELDERLY

## ANTICHOLINERGICS -

### CYPROHEPTADINE\_CARBINOXAMINE

---

#### Products Affected

- *cyproheptadine oral syrup*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK DRUGS IN THE ELDERLY- ANTICHOLINERGICS- DIPHENHYDRAMINE ELIXIR

## Products Affected

- *diphenhydramine hcl oral elixir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ANTIHISTAMINIC CONDITIONS (PRURITUS OR URTICARIA): TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. INSOMNIA: TRIAL OF SILENOR AND BELSOMRA. MOTION SICKNESS AND ANTIPARKINSONISM: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS AND ANAPHYLACTIC REACTIONS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# HIGH RISK DRUGS IN THE ELDERLY- DIPHENOXYLATE-ATROPINE

---

## Products Affected

- *diphenoxylate-atropine oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# HIGH RISK DRUGS IN THE ELDERLY- INDOMETHACIN

---

## Products Affected

- *indomethacin oral capsule 25 mg, 50 mg*
- *indomethacin oral capsule, extended release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# HIGH RISK DRUGS IN THE ELDERLY- MEGESTROL

## Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK DRUGS IN THE ELDERLY- PAROXETINE

---

## Products Affected

- *paroxetine hcl oral suspension*
- *paroxetine hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HIGH RISK MEDICATIONS IN THE ELDERLY- PHENOBARBITAL

## Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR TREATMENT OF EPILEPSY/SEIZURES IN PATIENTS WHO ARE NEWLY PRESCRIBED PHENOBARBITAL: PATIENT HAS NOT RESPONDED TO AT LEAST ONE ANTICONVULSANT OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# HYDROXYUREA

---

## Products Affected

- SIKLOS ORAL TABLET 100 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IBRUTINIB

---

## Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IBUPROFEN-FAMOTIDINE

---

## Products Affected

- *ibuprofen-famotidine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND HISTAMINE H2-RECEPTOR ANTAGONISTS: FAMOTIDINE, CIMETIDINE, OR NIZATIDINE, AND TRIAL OF GENERIC, FEDERAL LEGEND IBUPROFEN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# ICATIBANT

---

## Products Affected

- *icatibant*
- *sajazir*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HAE: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	HAE: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR TREATMENT OF ACUTE HAE ATTACKS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IDELALISIB

---

## Products Affected

- ZYDELIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# IMATINIB

---

## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS.
Other Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# INFIGRATINIB

---

## Products Affected

- TRUSELTIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# INFLIXIMAB

## Products Affected

- *infliximab*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, XELJANZ, TREMFYA, RINVOQ, SKYRIZI. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI, TREMFYA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: HUMIRA, STELARA, SKYRIZI. UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: HUMIRA, STELARA, XELJANZ, RINVOQ. RENEWAL: RA, AS, PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# INTERFERON ALFA-2B

## Products Affected

- INTRON A INJECTION RECON SOLN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HEPATITIS C: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).
<b>Coverage Duration</b>	6 MONTHS.
<b>Other Criteria</b>	HEPATITIS C: 1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B, 3) USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED AND 4) LIMITED TO TOTAL OF 24 MONTHS OF TREATMENT. FOLLICULAR LYMPHOMA: LIMITED TO TOTAL OF 18 MONTHS OF TREATMENT. ALL OTHER INDICATIONS: LIMITED TO TOTAL OF 1 YEAR OF TREATMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# INTERFERON FOR MS-AVONEX

---

## Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# INTERFERON FOR MS-BETASERON

---

## Products Affected

- BETASERON SUBCUTANEOUS KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# INTERFERON FOR MS-PLEGRIDY

---

## Products Affected

- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# INTERFERON GAMMA-1B

---

## Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPECTOSIS (SMO): PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	RENEWAL: CGD, SMO: 1) DEMONSTRATED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED HEMATOPOIETIC CELL TRANSPLANTATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IPILIMUMAB

## Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MEL: 4MO, RCC/CRC/HCC: 3MO, ALL OTHERS: 12MO. INITIAL/RENEWAL: CUTAN MEL: 6MO
Other Criteria	RENEWAL: ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# IVACAF TOR

## Products Affected

- KALYDECO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	CYSTIC FIBROSIS (CF); INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
<b>Coverage Duration</b>	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
<b>Other Criteria</b>	CF: INITIAL: NOT HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE. RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IVOSIDENIB

---

## Products Affected

- TIBSOVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IXAZOMIB

---

## Products Affected

- NINLARO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# IXEKIZUMAB

## Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: HUMIRA, COSENTYX, STELARA, ENBREL, SKYRIZI, TREMFYA. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL, XELJANZ, TREMFYA, RINVOQ, SKYRIZI. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, COSENTYX, XELJANZ, RINVOQ. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, RINVOQ. RENEWAL: PSO, PSA, AS, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LANADELUMAB

---

## Products Affected

- TAKHZYRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# LANREOTIDE

## Products Affected

- *lanreotide* ML
- SOMATULINE DEPOT  
SUBCUTANEOUS SYRINGE 120  
MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: INITIAL: THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY: INITIAL: 3 MOS, RENEWAL: 12 MOS.GEP-NETS, CARCINOID SYNDROME: 12 MOS.
Other Criteria	ACROMEGALY: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE GENERIC OCTREOTIDE INJECTION. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# LAPATINIB

---

## Products Affected

- *lapatinib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LAROTRECTINIB

---

## Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	APPROVAL FOR VITRAKVI ORAL SOLUTION: TRIAL OF VITRAKVI CAPSULES OR PATIENT IS UNABLE TO TAKE CAPSULE FORMULATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LEDIPASVIR-SOFOSBUVIR

## Products Affected

- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, AND 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, TIPRANA VIR/RITONAVIR, SOFOSBUVIR (AS A SINGLE AGENT), EPCLUSA, ZEPATIER, MAVYRET, OR VOSEVI. REQUESTS FOR HARVONI 45MG-200MG PELLETS: PATIENT IS UNABLE TO SWALLOW TABLETS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# LENALIDOMIDE

---

## Products Affected

- *lenalidomide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LENVATINIB

---

## Products Affected

- LENVIMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LETERMIVIR

---

## Products Affected

- PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML, 480 MG/24 ML
- PREVYMIS ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	4 MONTHS
<b>Other Criteria</b>	HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT): THERAPY WILL BE INITIATED BETWEEN DAY 0 AND DAY 28 POST TRANSPLANTATION AND PATIENT IS NOT RECEIVING THE MEDICATION BEYOND 100 DAYS POST TRANSPLANTATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LEUPROLIDE

## Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: CENTRAL PRECOCIOUS PUBERTY (CPP): FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: CPP: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	PROSTATE CANCER: 12 MONTHS. CPP: INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	CPP: INITIAL: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR BREAST DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR GENITAL DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). RENEWAL: 1) TANNER SCALE STAGING AT INITIAL DIAGNOSIS OF CPP HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) PATIENT HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LEUPROLIDE DEPOT

---

## Products Affected

- *leuprolide (3 month)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# LEUPROLIDE-ELIGARD

---

## Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LEUPROLIDE-LUPRON DEPOT

## Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
<b>Coverage Duration</b>	PROSTATE CA: 12 MOS. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: 6 MOS.
<b>Other Criteria</b>	INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. RENEWAL: ENDOMETRIOSIS: 1) IMPROVEMENT OF PAIN RELATED TO ENDOMETRIOSIS WHILE ON THERAPY, 2) RECEIVING CONCOMITANT ADD-BACK THERAPY (I.E., COMBINATION ESTROGEN-PROGESTIN OR PROGESTIN-ONLY CONTRACEPTIVE PREPARATION), 3) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 4) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LEVODOPA

---

## Products Affected

- INBRIJA INHALATION CAPSULE,  
W/INHALATION DEVICE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	PD: INITIAL: 1) NOT CURRENTLY TAKING MORE THAN 1600MG OF LEVODOPA PER DAY, AND 2) PHYSICIAN HAS OPTIMIZED DRUG THERAPY FOR PARKINSONS DISEASE. RENEWAL: IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF INBRIJA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# L-GLUTAMINE

## Products Affected

- ENDARI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	SICKLE CELL DISEASE(SCD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
<b>Coverage Duration</b>	INITIAL: 12 MONTHS. RENEWAL: LIFETIME.
<b>Other Criteria</b>	SCD: INITIAL: PATIENTS 18 YEARS OR OLDER: ONE OF THE FOLLOWING: 1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, 2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR 3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME. PATIENTS 5 TO 17 YEARS: APPROVED WITHOUT ADDITIONAL CRITERIA. RENEWAL: HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LIDOCAINE

## Products Affected

- *lidocaine hcl mucous membrane solution 4 % (40 mg/ml)*
- *lidocaine topical adhesive patch, medicated 5 %*
- *lidocaine topical ointment*
- **ZTLIDO**

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# LIDOCAINE PRILOCAINE

---

## Products Affected

- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

# LOMITAPIDE

---

## Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>1) DIAGNOSIS DETERMINED BY A) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, OR B) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR C) CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. 2) LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. 3) TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. 4) MEETS ONE OF THE FOLLOWING: A) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, B) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, C) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), D) STATIN INTOLERANCE, OR E) TRIAL OF ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LONCASTUXIMAB TESIRINE-LPYL

---

## Products Affected

- ZYNLONTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LORLATINIB

---

## Products Affected

- LORBRENA ORAL TABLET 100 MG,  
25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# LUMACAF TOR-IVACAF TOR

## Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CYSTIC FIBROSIS (CF): CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CF.
Age Restrictions	
Prescriber Restrictions	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: LIFETIME.
Other Criteria	CF: RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# LUMASIRAN

---

## Products Affected

- OXLUMO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MACITENTAN

## Products Affected

- OPSUMIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: 1) DOCUMENTED CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) OF 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	PAH: RENEWAL: 1) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE, OR 2) A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# MARGETUXIMAB-CMKB

---

## Products Affected

- MARGENZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MEPOLIZUMAB

## Products Affected

- NUCALA SUBCUTANEOUS AUTO-INJECTOR
- NUCALA SUBCUTANEOUS RECON SOLN
- NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. NASAL POLYPS: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: ASTHMA: 4 MO. NASAL POLYPS: 6 MO. OTHERS: 12 MO. RENEWAL: NASAL POLYPS, ASTHMA: 12 MO.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. NASAL POLYPS: PREVIOUS 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. RENEWAL: ASTHMA: 1) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR D) INCREASE IN PERCENT PREDICTED FEV1 FROM</p>
	<p>PRETREATMENT BASELINE. NASAL POLYPS: CLINICAL BENEFIT COMPARED TO BASELINE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# MIDOSTAURIN

---

## Products Affected

- RYDAPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MIFEPRISTONE

## Products Affected

- KORLYM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) 24-HR URINE FREE CORTISOL (2 OR MORE TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (2 OR MORE TESTS TO CONFIRM).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	CS: INITIAL: HYPERCORTISOLISM IS NOT A RESULT OF CHRONIC GLUCOCORTICOIDS. RENEWAL: 1) CONTINUES TO HAVE IMPROVEMENT OF GLUCOSE TOLERANCE OR STABLE GLUCOSE TOLERANCE (E.G., REDUCED A1C, IMPROVED FASTING GLUCOSE, ETC.), 2) CONTINUES TO HAVE TOLERABILITY TO KORLYM, AND 3) CONTINUES TO NOT BE A CANDIDATE FOR SURGICAL TREATMENT OR HAS FAILED SURGERY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MIGALASTAT

## Products Affected

- GALAFOLD

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	FABRY DISEASE: INITIAL: PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	FABRY DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.
<b>Coverage Duration</b>	INITIAL: 6 MOS. RENEWAL: 12 MOS.
<b>Other Criteria</b>	FABRY DISEASE: INITIAL: NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME), RENEWAL: 1) PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION, AND 2) NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MIGLUSTAT

---

## Products Affected

- *miglustat*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# MILTEFOSINE

---

## Products Affected

- IMPAVIDO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MOBOCERTINIB

---

## Products Affected

- EXKIVITY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# MOSUNETUZUMAB-AXGB

## Products Affected

- LUNSUMIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: INITIAL: 6 MONTHS. RENEWAL: 7 MONTHS.
Other Criteria	RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA: RENEWAL: 1) HAS ACHIEVED A PARTIAL RESPONSE TO TREATMENT, AND 2) HAS NOT PREVIOUSLY RECEIVED MORE THAN 17 CYCLES OF TREATMENT. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# NAFARELIN

## Products Affected

- SYNAREL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS. CENTRAL PRECOCIOUS PUBERTY (CPP): FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p>INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST. CPP: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.</p>
<b>Coverage Duration</b>	<p>ENDOMETRIOSIS: 6 MONTHS. CPP: INITIAL/RENEWAL: 12 MONTHS.</p>

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. CPP: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR BREAST DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR GENITAL DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). RENEWAL: CPP: 1) TANNER SCALE STAGING AT INITIAL DIAGNOSIS OF CPP HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NARCOLEPSY AGENTS

---

## Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NATALIZUMAB

## Products Affected

- TYSABRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	MULTIPLE SCLEROSIS (MS): 12 MOS. CD: INITIAL: 6 MOS, RENEWAL: 12 MOS.
Other Criteria	INITIAL: MS: TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF MS. CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, SKYRIZI. RENEWAL: CD: ONE OF THE FOLLOWING: 1) RECEIVED AT LEAST 12 MONTHS OF THERAPY WITH TYSABRI AND HAS NOT REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID USE WITHIN THE PAST 12 MONTHS TO CONTROL THEIR CROHNS DISEASE WHILE ON TYSABRI, OR 2) HAS ONLY RECEIVED 6 MONTHS OF THERAPY WITH TYSABRI AND HAS TAPERED OFF CORTICOSTEROIDS DURING THE FIRST 24 WEEKS OF TYSABRI THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# NAXITAMAB-GQGK

---

## Products Affected

- DANYELZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# NERATINIB MALEATE

---

## Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EARLY-STAGE (STAGE I-III) BREAST CANCER: MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# NILOTINIB

---

## Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUSLY TREATED CML: MUTATIONAL ANALYSIS PRIOR TO INITIATION AND TASIGNA IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NINTEDANIB

## Products Affected

- OFEV

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (PF-ILD): 1) AT LEAST 10% FIBROSIS ON A CHEST HRCT, AND 2) BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p>INITIAL: IPF: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.</p>
<b>Coverage Duration</b>	<p>INITIAL: SSC-ILD: 6 MOS. IPF, PF-ILD: 12 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.</p>

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: IPF: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ESBRIET (PIRFENIDONE). SSC-ILD: 1) DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., HEART FAILURE/FLUID OVERLOAD, DRUG-INDUCED LUNG TOXICITY, RECURRENT ASPIRATION), AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: ACTEMRA SUBQ. PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENERD/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC-ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NIRAPARIB

---

## Products Affected

- ZEJULA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: 1) ZEJULA WILL BE USED AS MONOTHERAPY, AND 2) ZEJULA IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NITISINONE

## Products Affected

- *nitisinone*
- ORFADIN ORAL CAPSULE 20 MG
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HEREDITARY TYROSINEMIA TYPE 1 (HT-1): INITIAL: DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE. RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HT-1: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	HT-1: INITIAL: ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED NITISINONE TABLETS OR CAPSULES.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NIVOLUMAB

---

## Products Affected

- OPDIVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# NIVOLUMAB-RELATLIMAB-RMBW

---

## Products Affected

- OPDUALAG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# OBETICHOLIC ACID

## Products Affected

- OCALIVA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	PRIMARY BILIARY CHOLANGITIS (PBC): INITIAL/RENEWAL: COMPLETE BILIARY OBSTRUCTION.
<b>Required Medical Information</b>	PBC: INITIAL: DIAGNOSIS CONFIRMED BY TWO OF THE FOLLOWING: 1) ALKALINE PHOSPHATASE LEVEL OF AT LEAST 1.5 TIMES THE UPPER LIMIT OF NORMAL, 2) PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES AT A TITER OF 1:40 OR HIGHER, OR 3) HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PBC: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	PBC: INITIAL: USED IN COMBINATION WITH URSODEOXYCHOLIC ACID IN A PATIENT WITH AN INADEQUATE RESPONSE TO URSODEOXYCHOLIC ACID, OR AS MONOTHERAPY IN A PATIENT WHO IS UNABLE TO TOLERATE URSODEOXYCHOLIC ACID. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OCRELIZUMAB

---

## Products Affected

- OCREVUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): TRIAL OF TWO AGENTS INDICATED FOR THE TREATMENT OF RELAPSING FORMS OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OFATUMUMAB-SQ

---

## Products Affected

- KESIMPTA PEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OLANZAPINE/SAMIDORPHAN

## Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SCHIZOPHRENIA/BIPOLAR I: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST
Coverage Duration	12 MONTHS
Other Criteria	SCHIZOPHRENIA: (1) PATIENT IS AT HIGH RISK OF WEIGHT GAIN AND (2) TRIAL OF OR CONTRAINDICATION TO LATUDA OR ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE. BIPOLAR I: (1) PATIENT IS AT HIGH RISK OF WEIGHT GAIN AND (2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# OLAPARIB

## Products Affected

- LYNPARZA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER: 1) MEDICATION WILL BE USED AS MONOTHERAPY, AND 2) PATIENT HAS COMPLETED TWO OR MORE LINES OF PLATINUM-BASED CHEMOTHERAPY. METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OLUTASIDENIB

---

## Products Affected

- REZLIDHIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OMACETAXINE

---

## Products Affected

- SYNRIBO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OMALIZUMAB

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL AND RENEWAL: CHRONIC IDIOPATHIC URTICARIA (CIU): PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY. INITIAL: NASAL POLYPS: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
<b>Coverage Duration</b>	INITIAL: ASTHMA: 12 MO. CIU, NASAL POLYPS: 6 MO. RENEWAL: ASTHMA, NASAL POLYPS: 12 MO. CIU: 6 MO.



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: CIU: TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE AND STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK. NASAL POLYPS: 1) PREVIOUS 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: NUCALA, DUPIXENT. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, 3) NOT CONCURRENTLY RECEIVING DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. RENEWAL: CIU: DIAGNOSIS OF CIU. NASAL POLYPS: CLINICAL BENEFIT COMPARED TO BASELINE. ASTHMA: 1) NOT CONCURRENTLY RECEIVING DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: A) REDUCTION IN ASTHMA</p>
	<p>EXACERBATIONS FROM BASELINE, B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE.</p>
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# OSIMERTINIB

---

## Products Affected

- TAGRISSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	EGFR EXON 19 DELETIONS OR EXON 21 L858R MUTATIONS NON-SMALL CELL LUNG CANCER (NSCLC) AND METASTATIC NSCLC WITH EGFR T790M MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PACRITINIB

---

## Products Affected

- VONJO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PALBOCICLIB

---

## Products Affected

- IBRANCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PANOBINOSTAT

---

## Products Affected

- FARYDAK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	MULTIPLE MYELOMA: RENEWAL: TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PARATHYROID HORMONE

---

## Products Affected

- NATPARA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	HYPOCALCEMIA SECONDARY TO HYPOPARATHYROIDISM: 1) TRIAL OF OR CONTRAINDICATION TO CALCITRIOL, 2) HYPOPARATHYROIDISM IS NOT DUE TO A CALCIUM SENSING RECEPTOR (CSR) MUTATION, AND 3) HYPOPARATHYROIDISM IS NOT CONSIDERED ACUTE POST-SURGICAL HYPOPARATHYROIDISM.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PASIREOTIDE DIASPARTATE

---

## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CUSHINGS DISEASE (CD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	CD: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE, AND 2) MAINTAINED TOLERABILITY TO SIGNIFOR.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# PAZOPANIB

---

## Products Affected

- VOTRIENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	ADVANCED SOFT TISSUE SARCOMA (STS): NOT USED FOR ADIPOCYTIC STS OR GASTROINTESTINAL STROMAL TUMORS (GIST)
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	PAH: INITIAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS, AND 2) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER. RENEWAL: 1) NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS, AND 2) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEGFILGRASTIM

---

## Products Affected

- NEULASTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NON MYELOID MALIGNANCY, ACUTE RADIATION EXPOSURE: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	NON MYELOID MALIGNANCY: TRIAL OF OR CONTRAINDICATION TO NYVEPRIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEGFILGRASTIM - APGF

---

## Products Affected

- NYVEPRIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NON MYELOID MALIGNANCY: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEGFILGRASTIM - CBQV

---

## Products Affected

- UDENYCA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NON MYELOID MALIGNANCY: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	NON MYELOID MALIGNANCY: TRIAL OF OR CONTRAINDICATION TO NYVEPRIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEGFILGRASTIM - JMDB

---

## Products Affected

- FULPHILA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NON MYELOID MALIGNANCY: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	NON MYELOID MALIGNANCY: TRIAL OF OR CONTRAINDICATION TO NYVEPRIA
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEGFILGRASTIM-NEULASTA ONPRO

---

## Products Affected

- NEULASTA ONPRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NON MYELOID MALIGNANCY, ACUTE RADIATION EXPOSURE: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# PEGVALIASE-PQPZ

---

## Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	PHENYLKETONURIA (PKU): INITIAL: NOT ON CONCURRENT TREATMENT WITH KUVAN. RENEWAL: 1) PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) NOT ON CONCURRENT TREATMENT WITH KUVAN .
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# PEGVISOMANT

---

## Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEMBROLIZUMAB

---

## Products Affected

- KEYTRUDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT USE WITH TARGETED THERAPY (I.E., BRAF INHIBITORS, MEK INHIBITORS, AND NTRK INHIBITORS).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEMIGATINIB

---

## Products Affected

- PEMAZYRE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PENICILLAMINE

## Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>INITIAL: WILSONS DISEASE: CONFIRMED BY ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN IS LESS THAN 20MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: PATIENT HAS NEPHROLITHIASIS AND ONE OR MORE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, 2) IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p>WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.</p>
<b>Coverage Duration</b>	<p>INITIAL: 12 MONTHS, RENEWAL: LIFETIME.</p>

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: WILSONS DISEASE: 1) KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE, AND 2) REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRE A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN). CYSTINURIA: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRES A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN) AND A FORMULARY VERSION OF TIOPRONIN (THIOLA)/THIOLA EC. RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, 2) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED, AND 3) REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRES A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN). RENEWAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, 2) EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT COMPARED TO BASELINE. WILSONS DISEASE, CYSTINURIA: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PEXIDARTINIB

---

## Products Affected

- TURALIO ORAL CAPSULE 200 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PIMAVANSERIN

---

## Products Affected

- NUPLAZID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	PSYCHOSIS IN PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OR OLDER
<b>Prescriber Restrictions</b>	PSYCHOSIS IN PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (E.G., PSYCHIATRIST).
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	PSYCHOSIS IN PD: RENEWAL: IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# PIRFENIDONE

## Products Affected

- ESBRIET ORAL CAPSULE
- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	IDIOPATHIC PULMONARY FIBROSIS (IPF): INITIAL: 1) A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT, AND 2) PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50% AT BASELINE.
<b>Age Restrictions</b>	IPF: INITIAL: 18 YEARS OR OLDER.
<b>Prescriber Restrictions</b>	IPF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	IPF: INITIAL: 1) DOES NOT HAVE 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). RENEWAL: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# POMALIDOMIDE

---

## Products Affected

- POMALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PONATINIB

---

## Products Affected

- ICLUSIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	CML: MUTATIONAL ANALYSIS PRIOR TO INITIATION AND ICLUSIG IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# POSACONAZOLE

## Products Affected

- NOXAFIL ORAL SUSPENSION
- *posaconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OROPHARYNGEAL CANDIDIASIS (OPC): 3 MONTHS. PROPHYLAXIS: 6 MONTHS. TREATMENT: 12 WEEKS.
Other Criteria	POSACONAZOLE SUSPENSION ONLY: 1) OPC: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE OR ITRACONAZOLE. 2) PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTION: INABILITY TO SWALLOW TABLETS. POSACONAZOLE TABLETS ONLY: TREATMENT OF INVASIVE ASPERGILLOSIS: NO EXTRA CRITERIA REQUIRED. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# POSACONAZOLE-POWDERMIX

---

## Products Affected

- NOXAFIL ORAL SUSP,DELAYED  
RELEASE FOR RECON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 MONTHS
<b>Other Criteria</b>	PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTION: INABILITY TO SWALLOW TABLETS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PRALSETINIB

---

## Products Affected

- GAVRETO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# PRAMLINTIDE

---

## Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# PYRIMETHAMINE

## Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	TOXOPLASMOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.
<b>Coverage Duration</b>	TOXOPLASMOSIS: INITIAL: 8 WEEKS, RENEWAL: 6 MOS.
<b>Other Criteria</b>	TOXOPLASMOSIS: RENEWAL: ONE OF THE FOLLOWING: (1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING), OR (2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENTLY TAKING AN ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# QUININE

---

## Products Affected

- *quinine sulfate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RAMUCIRUMAB

---

## Products Affected

- CYRAMZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# REGORAFENIB

---

## Products Affected

- STIVARGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RELUGOLIX

---

## Products Affected

- ORGOVYX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RESLIZUMAB

---

## Products Affected

- CINQAIR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
<b>Coverage Duration</b>	ASTHMA: INITIAL 4 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, 3) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: FASENRA, NUCALA, DUPIXENT, AND 4) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA.</p> <p>RENEWAL: 1) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. THIS DRUG ALSO REQUIRES</p>
	PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No



# RIBOCICLIB

## Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED OR METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO VERZENIO OR IBRANCE WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# RIFAXIMIN

---

## Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	TRAVELERS DIARRHEA/HE: 12 MOS. IBS-D: 8 WKS.
<b>Other Criteria</b>	RIFAXIMIN 550 MG TABLETS: HE: TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RIMEGEPANT

## Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: ACUTE MIGRAINE TREATMENT: TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN). EPISODIC MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: ACUTE MIGRAINE TREATMENT: 1) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR 2) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS. EPISODIC MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RIOCIQUAT

## Products Affected

- ADEMPAS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) II-IV SYMPTOMS. PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4: NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	<p>INITIAL: PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.</p>
<b>Coverage Duration</b>	<p>INITIAL AND RENEWAL: 12 MONTHS.</p>

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: PAH: NOT CONCURRENTLY TAKING NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NOT CONCURRENTLY TAKING NITRATES, NITRIC OXIDE DONORS, OR ANY PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: 1) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS, AND 2) NOT CONCURRENTLY TAKING NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RIPRETINIB

---

## Products Affected

- QINLOCK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RISANKIZUMAB-RZAA

## Products Affected

- SKYRIZI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). CD: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RISDIPLAM

## Products Affected

- EVRYSDI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	SPINAL MUSCULAR ATROPHY (SMA): INITIAL: GENE MUTATION ANALYSIS INDICATING MUTATIONS OR DELETIONS OF BOTH ALLELES OF THE SURVIVAL MOTOR NEURON 1 (SMN1) GENE. FOR PRESYMPTOMATIC PATIENTS: UP TO THREE COPIES OF SURVIVAL MOTOR NEURON 2 (SMN2) BASED ON NEWBORN SCREENING.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	SMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROMUSCULAR SPECIALIST OR SMA SPECIALIST AT A SMA SPECIALTY CENTER.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS
<b>Other Criteria</b>	SMA: INITIAL: FOR SYMPTOMATIC PATIENTS: (1) BASELINE MOTOR FUNCTION ASSESSMENT BY A NEUROMUSCULAR SPECIALIST OR SMA SPECIALIST, AND (2) IF PATIENT RECEIVED GENE THERAPY, THE PATIENT HAD LESS THAN EXPECTED CLINICAL BENEFIT. RENEWAL: IMPROVED, MAINTAINED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN: (1) MOTOR FUNCTION ASSESSMENTS COMPARED TO BASELINE, OR (2) OTHER MUSCLE FUNCTION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RITUXIMAB AND HYALURONIDASE HUMAN-SQ

---

## Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# RITUXIMAB-ABBS

## Products Affected

- TRUXIMA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
<b>Coverage Duration</b>	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, GPA, MPA: 12 MO. CLL: 6 MO.
<b>Other Criteria</b>	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RITUXIMAB-ARRX

## Products Affected

- RIABNI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
<b>Coverage Duration</b>	RA: INITIAL: 6 MO, RENEWAL: 12 MO. NHL, WG, MPA: 12 MO. CLL: 6 MO.
<b>Other Criteria</b>	RA: INITIAL: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RITUXIMAB-PVVR

## Products Affected

- RUXIENCE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
<b>Coverage Duration</b>	NHL, GPA, MPA: 12 MONTHS. CLL: 6 MONTHS. RA: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO PREFERRED AGENTS: HUMIRA, ENBREL, RINVOQ, XELJANZ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: RA: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ROPEGINTERFERON ALFA-2B-NJFT

---

## Products Affected

- BESREMI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# RUCAPARIB

---

## Products Affected

- RUBRACA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# RUXOLITINIB

---

## Products Affected

- JAKAFI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS.
<b>Other Criteria</b>	MYELOFIBROSIS: RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SAPROPTERIN

---

## Products Affected

- *javygtor oral tablet, soluble*
- *sapropterin oral tablet, soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 1 MONTH, RENEWAL 12 MONTHS.
Other Criteria	HYPERPHENYLALANINEMIA (HPA): INITIAL: NOT CONCURRENTLY USING PALYNZIQ. RENEWAL: 1) CONTINUES TO BENEFIT FROM TREATMENT, AND 2) NOT CONCURRENTLY USING PALYNZIQ.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# SARILUMAB

## Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	RA: INITIAL: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# SECUKINUMAB

## Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG). AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID, SULFASALAZINE, OR METHOTREXATE. RENEWAL: PSO, PSA, AS, NR-AXSPA, ERA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SELEXIPAG

## Products Affected

- UPTRAVI INTRAVENOUS
- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>PAH: INITIAL: WHO FC II-III SYMPTOMS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS, EACH FROM A DIFFERENT DRUG CLASS: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIAL RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR, OR 3) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR. WHO FC III SYMPTOMS AND EVIDENCE OF RAPID PROGRESSION OR POOR PROGNOSIS, WHO FC IV SYMPTOMS: NO STEP. RENEWAL: 1) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST, OR 2) REMAINED STABLE FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST AND WHO FC HAS IMPROVED OR REMAINED STABLE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SELINEXOR

---

## Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No



# SELPERCATINIB

---

## Products Affected

- RETEVMO ORAL CAPSULE 40 MG,  
80 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SELUMETINIB

---

## Products Affected

- KOSELUGO ORAL CAPSULE 10 MG,  
25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SIPONIMOD

## Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER(FOR 1MG MAINT)
- MAYZENT STARTER(FOR 2MG MAINT)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MULTIPLE SCLEROSIS: RENEWAL: 1) DEMONSTRATION OF CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE AND 2) DOES NOT HAVE LYMPHOPENIA.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# SIROLIMUS PROTEIN-BOUND

---

## Products Affected

- FYARRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SODIUM OXYBATE

## Products Affected

- *sodium oxybate*
- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE.
Coverage Duration	INITIAL 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: 1) NOT CURRENTLY TAKING A SEDATIVE HYPNOTIC AGENT, 2) FOR PATIENTS 18 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO THE FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, PITOLISANT OR SOLRIAMFETOL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY, AND 3) FOR PATIENTS 7 TO 17 YEARS OF AGE: TRIAL OF OR CONTRAINDICATION TO ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. CATAPLEXY IN NARCOLEPSY: NOT CURRENTLY TAKING A SEDATIVE HYPNOTIC AGENT. RENEWAL (ALL INDICATIONS): 1) SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE, AND 2) NOT CURRENTLY TAKING A SEDATIVE HYPNOTIC AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# SOFOSBUVIR/VELPATASVIR

## Products Affected

- EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG
- EPCLUSA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANA VIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

## Products Affected

- VOSEVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR, TIPRANAVIR/RITONAVIR, SOVALDI (AS A SINGLE AGENT), EPCLUSA, HARVONI, ZEPATIER, OR MAVYRET, AND 3) DOES NOT HAVE MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Part B Prerequisite</b>	No

# SOLRIAMFETOL

---

## Products Affected

- SUNOSI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: EDS IN NARCOLEPSY: TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL, AND ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. EDS IN OBSTRUCTIVE SLEEP APNEA (OSA): TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL. RENEWAL: EDS IN NARCOLEPSY OR OSA: SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SOMATROPIN - NORDITROPIN

---

## Products Affected

- NORDITROPIN FLEXPPO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
<b>Required Medical Information</b>	INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. RENEWAL: PEDIATRIC GHD: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND OR PATIENT HAS NOT COMPLETED PREPUBERTALGROWTH. ISS, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PWS: IMPROVEMENT IN BODY COMPOSITION.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SOMATROPIN - SEROSTIM

## Products Affected

- SEROSTIM SUBCUTANEOUS  
RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
<b>Required Medical Information</b>	INITIAL: HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 1) 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 2) 7.5% UNINTENTIONAL WEIGHT LOSS OVER 6 MONTHS, 3) 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, 4) BODY CELL MASS (BCM) LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 5) BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR 6) BMI LESS THAN 18.5 KG PER METER SQUARED.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HIV/WASTING: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 3 MONTHS.
<b>Other Criteria</b>	HIV/WASTING: INITIAL: 1) CURRENTLY ON HIV ANTIRETROVIRAL THERAPY, AND 2) INADEQUATE RESPONSE TO ONE PREVIOUS THERAPY (E.G., MEGACE, APPETITE STIMULANTS, ANABOLIC STEROIDS). RENEWAL: 1) CURRENTLY ON HIV ANTIRETROVIRAL THERAPY, AND 2) CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT.
<b>Indications</b>	All FDA-approved Indications.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SONIDEGIB

---

## Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	LOCALLY ADVANCED BASAL CELL CARCINOMA (BCC); BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SORAFENIB

---

## Products Affected

- *sorafenib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# SOTORASIB

---

## Products Affected

- LUMAKRAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# STIRIPENTOL

---

## Products Affected

- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	DRAVET SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
<b>Coverage Duration</b>	INITIAL/RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# SUNITINIB

---

## Products Affected

- *sunitinib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO IMATINIB (GLEEVEC).
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TALAZOPARIB

---

## Products Affected

- TALZENNA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PATIENT HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER MUST HAVE ADDITIONAL PRIOR TREATMENT WITH ENDOCRINE THERAPY OR BE CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TALIMOGENE

## Products Affected

- IMLYGIC INJECTION SUSPENSION  
10EXP6 (1 MILLION) PFU/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	UNRESECTABLE MELANOMA: 1) IMLYGIC TO BE INJECTED INTO CUTANEOUS, SUBCUTANEOUS, AND/OR NODAL LESIONS THAT ARE VISIBLE, PALPABLE, OR DETECTABLE BY ULTRASOUND GUIDANCE, 2) NOT CURRENTLY RECEIVING IMMUNOSUPPRESSIVE THERAPY, 3) NO HISTORY OF PRIMARY OR ACQUIRED IMMUNODEFICIENT STATES, LEUKEMIA, LYMPHOMA, OR AIDS, AND 4) NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# TASIMELTEON

---

## Products Affected

- HETLIOZ
- *tasimelteon*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	LIFETIME
<b>Other Criteria</b>	NON-24 HOUR SLEEP-WAKE DISORDER: PATIENT IS LIGHT-INSENSITIVE OR HAS TOTAL BLINDNESS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TAZEMETOSTAT

---

## Products Affected

- TAZVERIK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TBO-FILGRASTIM

---

## Products Affected

- GRANIX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NON-MYELOID MALIGNANCIES: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	NON-MYELOID MALIGNANCIES: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: NIVESTYM.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# TEBENTAFUSP-TEBN

---

## Products Affected

- KIMMTRAK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TECLISTAMAB-CQYV

---

## Products Affected

- TECVAYLI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TEDUGLUTIDE

---

## Products Affected

- GATTEX 30-VIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	SHORT BOWEL SYNDROME (SBS): INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
<b>Other Criteria</b>	SBS: INITIAL: PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK. RENEWAL: ACHIEVED OR MAINTAINED A DECREASED NEED FOR PARENTERAL SUPPORT COMPARED TO BASELINE.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TELOTRISTAT

---

## Products Affected

- XERMELO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CARCINOID SYNDROME DIARRHEA: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR GASTROENTEROLOGIST
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TEPOTINIB

---

## Products Affected

- TEPMETKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TERIFLUNOMIDE

---

## Products Affected

- AUBAGIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TERIPARATIDE

---

## Products Affected

- FORTEO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>OSTEOPOROSIS: ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S), B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.), C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE, (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE), (3) TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO ONE BISPHOSPHONATE. PATIENT HAS NOT RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT UNLESS PATIENT REMAINS AT OR HAS RETURNED TO HAVING A HIGH RISK FOR FRACTURE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# TESAMORELIN

---

## Products Affected

- EGRIFTA SV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TESTOSTERONE

## Products Affected

- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 12.5 mg/1.25 gram (1%), 20.25 mg/1.25 gram (1.62%)*
- *testosterone transdermal gel in packet 1% (25 mg/2.5gram), 1% (50 mg/5 gram)*
- *testosterone transdermal solution in metered pump w/lapp*
- XYOSTED

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: MALE HYPOGONADISM: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 NG/DL.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	MALE HYPOGONADISM: INITIAL/RENEWAL:12 MO. ALL OTHER INDICATIONS: LIFETIME OF MEMBERSHIP IN PLAN.
<b>Other Criteria</b>	RENEWAL: MALE HYPOGONADISM: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TETRABENAZINE

---

## Products Affected

- *tetrabenazine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TEZACAFTOR/IVACAFTOR

## Products Affected

- SYMDEKO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	CYSTIC FIBROSIS (CF); INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: LIFETIME
<b>Other Criteria</b>	CF: RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# THALIDOMIDE

---

## Products Affected

- THALOMID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TISOTUMAB VEDOTIN-TFTV

---

## Products Affected

- TIVDAK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TIVOZANIB

---

## Products Affected

- FOTIVDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TOCILIZUMAB IV

## Products Affected

- ACTEMRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
<b>Coverage Duration</b>	INITIAL: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TOCILIZUMAB SQ

---

## Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). SSC-ILD: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS). RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. SSC-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TOFACITINIB

## Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA, PCJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. RENEWAL: RA, PSA, AS, PCJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TOPICAL TRETINOIN

---

## Products Affected

- ALTRENO
- *tretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ACNE VULGARIS: BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A GENERIC TOPICAL TRETINOIN PRODUCT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# TRAMETINIB

---

## Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRASTUZUMAB HYALURONIDASE

---

## Products Affected

- HERCEPTIN HYLECTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	ADJUVANT BREAST CANCER, METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: HERZUMA, OGIVRI, ONTRUZANT, TRAZIMERA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# TRASTUZUMAB-DKST

---

## Products Affected

- OGIVRI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRASTUZUMAB-DTTB

---

## Products Affected

- ONTRUZANT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRASTUZUMAB-PKRB

---

## Products Affected

- HERZUMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRASTUZUMAB-QYYP

---

## Products Affected

- TRAZIMERA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TREMELIMUMAB-ACTL

---

## Products Affected

- IMJUDO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	UHCC: 30 DAYS. METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC): 5 MONTHS.
<b>Other Criteria</b>	UNRESECTABLE HEPATOCELLULAR CARCINOMA (UHCC): HAS NOT RECEIVED PRIOR TREATMENT WITH IMJUDO.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRIENTINE

## Products Affected

- *trientine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	WILSONS DISEASE: INITIAL: KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE. CONFIRMATION OF ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	WILSONS DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 12 MONTHS, RENEWAL: LIFETIME.
<b>Other Criteria</b>	WILSONS DISEASE: INITIAL: TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF PENICILLAMINE (DEPEN). RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRIFLURIDINE/TIPIRACIL

---

## Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# TRIPTORELIN-TRELSTAR

---

## Products Affected

- TRELSTAR INTRAMUSCULAR  
SUSPENSION FOR  
RECONSTITUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS.
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# TUCATINIB

---

## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# UBROGEPANT

---

## Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	ACUTE MIGRAINE TREATMENT: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN). RENEWAL: 1) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR 2) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

# UPADACITINIB

---

## Products Affected

- RINVOQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: RA, AS, NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. UC: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. ATOPIC DERMATITIS: 1) ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS, 2) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 3) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING: TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR, AND 4) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR THE TREATMENT OF ATOPIC DERMATITIS. UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). RENEWAL: RA, PSA, AS, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION. ATOPIC DERMATITIS: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR THE TREATMENT OF ATOPIC DERMATITIS.</p>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# USTEKINUMAB

## Products Affected

- STELARA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# USTEKINUMAB IV

---

## Products Affected

- STELARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	2 MONTHS
<b>Other Criteria</b>	CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VANDETANIB

---

## Products Affected

- CAPRELSA ORAL TABLET 100 MG,  
300 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	CURRENTLY STABLE ON CAPRELSA REQUIRES NO EXTRA CRITERIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



# VEMURAFENIB

---

## Products Affected

- ZELBORAF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	MELANOMA: ZELBORAF WILL BE USED ALONE OR IN COMBINATION WITH COTELLIC
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VENETOCLAX

---

## Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VIGABATRIN

---

## Products Affected

- *vigabatrin*
- *vigadrone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	CPS: 1) TRIAL OF OR CONTRAINDICATION TO TWO ANTIPILEPTIC AGENTS AND 2) BENEFITS OUTWEIGH THE POTENTIAL FOR VISION LOSS. INFANTILE SPASMS: BENEFITS OUTWEIGH THE POTENTIAL FOR VISION LOSS.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VISMODEGIB

---

## Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# VORICONAZOLE SUSPENSION

---

## Products Affected

- *voriconazole oral suspension for reconstitution*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	CANDIDA INFECTIONS: 3 MOS. ALL OTHER INDICATIONS: 6 MOS.
<b>Other Criteria</b>	CANDIDA INFECTIONS: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE. ALL INDICATIONS: INABILITY TO SWALLOW TABLETS OR AN INDICATION FOR ESOPHAGEAL CANDIDIASIS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

# ZANUBRUTINIB

---

## Products Affected

- BRUKINSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



## INDEX

<i>abiraterone</i> .....	8	BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG.....	50
ACTEMRA.....	335, 337	BRAFTOVI ORAL CAPSULE 75 MG	104
ACTEMRA ACTPEN.....	337	BRUKINSA.....	365
ACTHAR.....	68	<i>butalbital-acetaminophen-caff oral tablet</i>	139
ACTIMMUNE.....	168	<i>butalbital-aspirin-caffeine</i> .....	139
ADEMPAS.....	276	CABLIVI INJECTION KIT.....	57
AJOVY AUTOINJECTOR.....	124	CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG.....	55
AJOVY SYRINGE.....	124	CALQUENCE.....	10
ALECENSA.....	15	CALQUENCE (ACALABRUTINIB MAL).....	10
ALTRENO.....	341	CAPRELSA ORAL TABLET 100 MG, 300 MG.....	359
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG.....	51	<i>carglumic acid</i> .....	59
ALUNBRIG ORAL TABLETS,DOSE PACK.....	51	CAYSTON.....	33
<i>alyq</i> .....	241	CERDELGA.....	99
<i>amabelz</i> .....	142	<i>chlorzoxazone oral tablet 500 mg</i> .....	146
<i>ambrisentan</i> .....	17	CIMZIA.....	61
<i>apomorphine</i> .....	20	CIMZIA POWDER FOR RECONST....	61
<i>armodafinil</i> .....	213	CINQAIR.....	269
<i>ascomp with codeine</i> .....	139	CINRYZE.....	52
AUBAGIO.....	325	<i>codeine-butalbital-asa-caff</i> .....	139
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG.....	84	<i>colchicine oral tablet</i> .....	67
AVONEX INTRAMUSCULAR PEN INJECTOR KIT.....	165	COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY).....	54
AVONEX INTRAMUSCULAR SYRINGE KIT.....	165	COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML.....	131
AYVAKIT.....	29	COPIKTRA.....	95
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG.....	109	CORTROPHIN GEL.....	68
<i>bendamustine intravenous recon soln</i> .....	39	COSENTYX (2 SYRINGES).....	291
BENDEKA.....	39	COSENTYX PEN (2 PENS).....	291
BENLYSTA SUBCUTANEOUS.....	36	COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML.....	291
BESREMI.....	286	COTELLIC.....	66
<i>betaine</i> .....	42	<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i> ..	146
BETASERON SUBCUTANEOUS KIT .....	166	<i>cyproheptadine oral syrup</i> .....	147
<i>bexarotene</i> .....	45	CYRAMZA.....	266
<i>bortezomib injection recon soln 1 mg, 2.5 mg</i> .....	47	CYSTARAN.....	71
BORTEZOMIB INTRAVENOUS RECON SOLN.....	47	<i>dalfampridine</i> .....	74
		DANYELZA.....	215



DAURISMO ORAL TABLET 100	ERBITUX.....	63
MG, 25 MG.....	ERIVEDGE.....	363
<i>deferasirox</i> .....	ERLEADA.....	19
<i>deferiprone</i> .....	<i>erlotinib oral tablet 100 mg, 150 mg, 25</i>	
DIACOMIT ORAL CAPSULE 250	<i>mg</i> .....	110
MG, 500 MG.....	ESBRIET ORAL CAPSULE.....	256
DIACOMIT ORAL POWDER IN	<i>estradiol oral</i> .....	142
PACKET 250 MG, 500 MG.....	<i>estradiol transdermal patch semiweekly</i> ...	142
<i>diclofenac sodium topical gel 3 %</i> .....	<i>estradiol transdermal patch weekly</i> .....	142
<i>diclofenac sodium topical solution in</i>	<i>estradiol-norethindrone acet oral tablet</i>	
<i>metered-dose pump</i> .....	<i>0.5-0.1 mg</i> .....	142
<i>dimethyl fumarate oral capsule, delayed</i>	<i>everolimus (antineoplastic) oral tablet 10</i>	
<i>release(drlec) 120 mg, 120 mg (14)- 240</i>	<i>mg, 2.5 mg, 5 mg, 7.5 mg</i> .....	114
<i>mg (46), 240 mg</i> .....	<i>everolimus (antineoplastic) oral tablet for</i>	
<i>diphenhydramine hcl oral elixir</i> .....	<i>suspension</i> .....	114
<i>diphenoxylate-atropine oral tablet</i> .....	EVRYSDI.....	281
<i>dipyridamole oral</i> .....	EXKIVITY.....	209
<i>disopyramide phosphate oral capsule</i> .....	FARYDAK.....	237
DOPTELET (10 TAB PACK).....	FASENRA.....	40
DOPTELET (15 TAB PACK).....	FASENRA PEN.....	40
DOPTELET (30 TAB PACK).....	<i>fentanyl citrate buccal lozenge on a</i>	
<i>dotti</i> .....	<i>handle</i> .....	117
<i>dronabinol</i> .....	FERRIPROX (2 TIMES A DAY).....	81
<i>droxidopa</i> .....	FERRIPROX ORAL SOLUTION.....	81
DUAVEE.....	<i> fingolimod</i> .....	122
DUPIXENT PEN.....	FINTEPLA.....	116
DUPIXENT SYRINGE.....	FORTEO.....	326
EGRIFTA SV.....	FOTIVDA.....	334
ELIGARD.....	FULPHILA.....	246
ELIGARD (3 MONTH).....	FYARRO.....	299
ELIGARD (4 MONTH).....	<i>fyavolv</i> .....	142
ELIGARD (6 MONTH).....	GALAFOLD.....	206
EMGALITY PEN.....	GAMIFANT.....	101
EMGALITY SYRINGE	GATTEX 30-VIAL.....	322
SUBCUTANEOUS SYRINGE 120	GAVRETO.....	262
MG/ML, 300 MG/3 ML (100 MG/ML	GILENYA ORAL CAPSULE 0.25 MG	
X 3).....	.....	122
ENBREL.....	GILOTRIF.....	14
ENBREL MINI.....	<i>glatiramer subcutaneous syringe 20</i>	
ENBREL SURECLICK.....	<i>mg/ml, 40 mg/ml</i> .....	131
ENDARI.....	<i>glatopa subcutaneous syringe 20 mg/ml,</i>	
EPCLUSA ORAL PELLETS IN	<i>40 mg/ml</i> .....	131
PACKET 150-37.5 MG, 200-50 MG.....	<i>glyburide</i> .....	144
EPCLUSA ORAL TABLET.....	<i>glyburide micronized</i> .....	144
EPIDIOLEX.....	<i>glyburide-metformin</i> .....	144

GRANIX.....	319	INLYTA ORAL TABLET 1 MG, 5	
HAEGARDA SUBCUTANEOUS		MG.....	31
RECON SOLN 2,000 UNIT, 3,000		INQOVI.....	78
UNIT.....	53	INREBIC.....	115
HARVONI ORAL PELLETS IN		INTRON A INJECTION RECON	
PACKET 33.75-150 MG, 45-200 MG...	179	SOLN.....	164
HARVONI ORAL TABLET.....	179	IRESSA.....	128
HERCEPTIN HYLECTA.....	343	JAKAFI.....	288
HERZUMA.....	346	<i>javygtor oral tablet, soluble</i> .....	289
HETLIOZ.....	317	JEMPERLI.....	89
HUMIRA PEN.....	12	<i>jinteli</i> .....	142
HUMIRA PEN CROHNS-UC-HS		JUXTAPID ORAL CAPSULE 10 MG,	
START.....	12	20 MG, 30 MG, 40 MG, 5 MG, 60 MG	193
HUMIRA PEN PSOR-UVEITS-ADOL		KALYDECO.....	170
HS.....	12	KERENDIA.....	121
HUMIRA SUBCUTANEOUS		KESIMPTA PEN.....	226
SYRINGE KIT 40 MG/0.8 ML.....	12	<i>ketorolac oral</i> .....	145
HUMIRA(CF).....	12	KEVZARA.....	290
HUMIRA(CF) PEDI CROHNS		KEYTRUDA.....	250
STARTER.....	12	KIMMTRAK.....	320
HUMIRA(CF) PEN.....	12	KISQALI FEMARA CO-PACK ORAL	
HUMIRA(CF) PEN CROHNS-UC-HS.	12	TABLET 200 MG/DAY(200 MG X 1)-	
HUMIRA(CF) PEN PEDIATRIC UC...	12	2.5 MG, 400 MG/DAY(200 MG X 2)-	
HUMIRA(CF) PEN PSOR-UV-ADOL		2.5 MG, 600 MG/DAY(200 MG X 3)-	
HS.....	12	2.5 MG.....	272
IBRANCE.....	236	KISQALI ORAL TABLET 200	
<i>ibuprofen-famotidine</i> .....	157	MG/DAY (200 MG X 1), 400 MG/DAY	
<i>icatibant</i> .....	158	(200 MG X 2), 600 MG/DAY (200 MG	
ICLUSIG.....	259	X 3).....	272
IDHIFA.....	103	KORLYM.....	205
<i>imatinib oral tablet 100 mg, 400 mg</i> .....	160	KOSELUGO ORAL CAPSULE 10	
IMBRUVICA ORAL CAPSULE 140		MG, 25 MG.....	297
MG, 70 MG.....	156	KRAZATI.....	11
IMBRUVICA ORAL SUSPENSION...	156	KYNMOBI SUBLINGUAL FILM 10	
IMBRUVICA ORAL TABLET.....	156	MG, 10-15-20-25-30 MG, 15 MG, 20	
IMJUDO.....	348	MG, 25 MG, 30 MG.....	21
IMLYGIC INJECTION SUSPENSION		<i>lanreotide</i> .....	176
10EXP6 (1 MILLION) PFU/ML.....	316	<i>lapatinib</i> .....	177
IMPAVIDO.....	208	<i>lenalidomide</i> .....	180
INBRIJA INHALATION CAPSULE,		LENVIMA.....	181
W/INHALATION DEVICE.....	189	<i>leuprolide (3 month)</i> .....	185
<i>indomethacin oral capsule 25 mg, 50 mg</i> ..	151	<i>leuprolide subcutaneous kit</i> .....	183
<i>indomethacin oral capsule, extended</i>		<i>lidocaine hcl mucous membrane solution 4</i>	
<i>release</i> .....	151	% (40 mg/ml).....	191
<i>infliximab</i> .....	162		

<i>lidocaine topical adhesive patch, medicated</i>	NATPARA.....	238
5 %.....	NERLYNX.....	216
<i>lidocaine topical ointment</i> .....	NEULASTA.....	243
191	NEULASTA ONPRO.....	247
<i>lidocaine-prilocaine topical cream</i> .....	NINLARO.....	172
192	<i>nitisinone</i> .....	221
LONSURF ORAL TABLET 15-6.14	NIVESTYM.....	118
MG, 20-8.19 MG.....	NORDITROPIN FLEXPOR.....	306
350	<i>norethindrone ac-eth estradiol oral tablet</i>	
LORBRENA ORAL TABLET 100	0.5-2.5 mg-mcg, 1-5 mg-mcg.....	142
MG, 25 MG.....	NOXAFIL ORAL SUSP, DELAYED	
196	RELEASE FOR RECON.....	261
LUMAKRAS.....	NOXAFIL ORAL SUSPENSION.....	260
312	NUBEQA.....	75
LUNSUMIO.....	NUCALA SUBCUTANEOUS AUTO-	
210	INJECTOR.....	201
LUPRON DEPOT.....	NUCALA SUBCUTANEOUS RECON	
187	SOLN.....	201
LUPRON DEPOT (3 MONTH).....	NUCALA SUBCUTANEOUS	
187	SYRINGE 100 MG/ML, 40 MG/0.4	
LUPRON DEPOT (4 MONTH).....	ML.....	201
187	NUPLAZID.....	255
LUPRON DEPOT (6 MONTH).....	NURTEC ODT.....	274
187	NYVEPRIA.....	244
LYBALVI.....	OCALIVA.....	224
227	OCREVUS.....	225
<i>lyllana</i> .....	ODOMZO.....	310
142	OFEV.....	218
LYNPARZA.....	OGIVRI.....	344
228	OLUMIANT.....	34
LYTGOBI.....	ONTRUZANT.....	345
125	ONUREG.....	32
MARGENZA.....	OPDIVO.....	222
200	OPDUALAG.....	223
MAVENCLAD (10 TABLET PACK)....	OPSUMIT.....	199
64	ORENCIA.....	5
MAVENCLAD (4 TABLET PACK).....	ORENCIA (WITH MALTOSE).....	3
64	ORENCIA CLICKJECT.....	5
MAVENCLAD (5 TABLET PACK).....	ORFADIN ORAL CAPSULE 20 MG.....	221
64	ORFADIN ORAL SUSPENSION.....	221
MAVENCLAD (6 TABLET PACK).....	ORGOVYX.....	268
64	ORLISSA ORAL TABLET 150 MG,	
MAVENCLAD (7 TABLET PACK).....	200 MG.....	96
64	ORKAMBI ORAL GRANULES IN	
MAVENCLAD (8 TABLET PACK).....	PACKET.....	197
64		
MAVENCLAD (9 TABLET PACK).....		
64		
MAZENT ORAL TABLET 0.25 MG,		
1 MG, 2 MG.....		
298		
MAYZENT STARTER(FOR 1MG		
MAINT).....		
298		
MAYZENT STARTER(FOR 2MG		
MAINT).....		
298		
<i>megestrol oral suspension 400 mg/10 ml</i>		
<i>(40 mg/ml)</i> .....		
152		
<i>megestrol oral tablet</i> .....		
152		
MEKINIST ORAL TABLET 0.5 MG, 2		
MG.....		
342		
MEKTOVI.....		
46		
<i>methocarbamol oral tablet 500 mg, 750</i>		
<i>mg</i> .....		
146		
<i>miglustat</i> .....		
207		
<i>mimvey</i> .....		
142		
<i>modafinil oral tablet 100 mg, 200 mg</i> .....		
213		
<i>morphine concentrate oral solution</i> .....		
135		
MVASI.....		
43		

ORKAMBI ORAL TABLET.....	197	RAVICTI.....	132
OTEZLA.....	22	RELEUKO.....	119
OTEZLA STARTER.....	22	RETACRIT INJECTION SOLUTION	
OXLUMO.....	198	10,000 UNIT/ML, 2,000 UNIT/ML,	
PALYNZIQ.....	248	20,000 UNIT/2 ML, 20,000 UNIT/ML,	
<i>paroxetine hcl oral suspension</i> .....	153	3,000 UNIT/ML, 4,000 UNIT/ML,	
<i>paroxetine hcl oral tablet</i> .....	153	40,000 UNIT/ML.....	107
PEMAZYRE.....	251	RETEVMO ORAL CAPSULE 40 MG,	
<i>penicillamine oral tablet</i> .....	252	80 MG.....	296
<i>phenobarbital</i> .....	154	REZLIDHIA.....	229
PIQRAY ORAL TABLET 200		REZUROCK.....	37
MG/DAY (200 MG X 1), 250 MG/DAY		RIABNI.....	284
(200 MG X1-50 MG X1), 300 MG/DAY		RINVOQ.....	354
(150 MG X 2).....	16	RITUXAN HYCELA.....	282
<i>pirfenidone oral capsule</i> .....	256	ROZLYTREK ORAL CAPSULE 100	
<i>pirfenidone oral tablet 267 mg, 534 mg,</i>		MG, 200 MG.....	105
<i>801 mg</i> .....	256	RUBRACA.....	287
PLEGRIDY SUBCUTANEOUS PEN		RUXIENCE.....	285
INJECTOR 125 MCG/0.5 ML, 63		RYBREVANT.....	18
MCG/0.5 ML- 94 MCG/0.5 ML.....	167	RYDAPT.....	204
PLEGRIDY SUBCUTANEOUS		<i>sajazir</i> .....	158
SYRINGE 125 MCG/0.5 ML, 63		<i>sapropterin oral tablet, soluble</i> .....	289
MCG/0.5 ML- 94 MCG/0.5 ML.....	167	SCEMBLIX.....	24
POMALYST.....	258	<i>scopolamine base</i> .....	138
<i>posaconazole</i> .....	260	SEROSTIM SUBCUTANEOUS	
PREMARIN ORAL.....	142	RECON SOLN 4 MG, 5 MG, 6 MG....	308
PREMPHASE.....	142	SIGNIFOR.....	239
PREMPRO.....	142	SIKLOS ORAL TABLET 100 MG.....	155
PREVYMIS INTRAVENOUS		<i>sildenafil (pulm.hypertension) oral tablet</i>	241
SOLUTION 240 MG/12 ML, 480		SIRTURO.....	35
MG/24 ML.....	182	SKYRIZI.....	279
PREVYMIS ORAL.....	182	<i>sodium oxybate</i> .....	300
PROMACTA ORAL POWDER IN		SOMATULINE DEPOT	
PACKET 12.5 MG, 25 MG.....	100	SUBCUTANEOUS SYRINGE 120	
PROMACTA ORAL TABLET 12.5		MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3	
MG, 25 MG, 50 MG, 75 MG.....	100	ML.....	176
<i>promethazine injection solution</i> .....	136	SOMAVERT.....	249
<i>promethazine oral</i> .....	136	<i>sorafenib</i> .....	311
<i>promethazine rectal</i> .....	136	SPRAVATO.....	111
<i>promethegan rectal suppository 12.5 mg,</i>		SPRYCEL ORAL TABLET 100 MG,	
<i>25 mg</i> .....	136	140 MG, 20 MG, 50 MG, 70 MG, 80	
<i>pyrimethamine</i> .....	264	MG.....	77
QINLOCK.....	278	STELARA.....	356, 358
<i>quinine sulfate</i> .....	265	STIVARGA.....	267
QULIPTA.....	28	STRENSIQ.....	25

<i>sunitinib</i> .....	314	<i>trientine</i> .....	349
SUNOSI.....	305	TRIKAFTA.....	98
SYMDEKO.....	331	TRUSELTIQ.....	161
SYMLINPEN 120.....	263	TRUXIMA.....	283
SYMLINPEN 60.....	263	TUKYSA ORAL TABLET 150 MG, 50	
SYMPAZAN.....	65	MG.....	352
SYNAREL.....	211	TURALIO ORAL CAPSULE 200 MG	254
SYNRIBO.....	230	TYMLOS.....	1
TABRECTA.....	58	TYSABRI.....	214
<i>tadalafil (pulm. hypertension)</i> .....	241	UBRELVY.....	353
TAFINLAR.....	72	UDENYCA.....	245
TAGRISSE.....	234	UPTRAVI INTRAVENOUS.....	293
TAKHZYRO.....	175	UPTRAVI ORAL TABLET 1,000	
TALTZ AUTOINJECTOR.....	173	MCG, 1,200 MCG, 1,400 MCG, 1,600	
TALTZ SYRINGE.....	173	MCG, 200 MCG, 400 MCG, 600 MCG,	
TALZENNA.....	315	800 MCG.....	293
TASCENSO ODT.....	123	UPTRAVI ORAL TABLETS,DOSE	
TASIGNA ORAL CAPSULE 150 MG,		PACK.....	293
200 MG, 50 MG.....	217	VELCADE.....	47
<i>tasimelteon</i> .....	317	VENCLEXTA ORAL TABLET 10	
TAZVERIK.....	318	MG, 100 MG, 50 MG.....	361
TECVAYLI.....	321	VENCLEXTA STARTING PACK.....	361
TEPMETKO.....	324	VERZENIO.....	7
<i>testosterone cypionate</i> .....	329	<i>vigabatrin</i> .....	362
<i>testosterone enanthate</i> .....	329	<i>vigadrone</i> .....	362
<i>testosterone transdermal gel in metered-</i>		VITRAKVI ORAL CAPSULE 100	
<i>dose pump 12.5 mg/1.25 gram (1%),</i>		MG, 25 MG.....	178
<i>20.25 mg/1.25 gram (1.62%)</i> .....	329	VITRAKVI ORAL SOLUTION.....	178
<i>testosterone transdermal gel in packet 1%</i>		VIZIMPRO.....	73
<i>(25 mg/2.5gram), 1% (50 mg/5 gram)</i> ...	329	VONJO.....	235
<i>testosterone transdermal solution in</i>		<i>voriconazole oral suspension for</i>	
<i>metered pump w/lapp</i> .....	329	<i>reconstitution</i> .....	364
<i>tetrabenazine</i> .....	330	VOSEVI.....	303
THALOMID.....	332	VOTRIENT.....	240
TIBSOVO.....	171	VUMERITY.....	88
TIVDAK.....	333	WELIREG.....	38
TRACLEER ORAL TABLET.....	48	XALKORI.....	70
TRACLEER ORAL TABLET FOR		XELJANZ.....	339
SUSPENSION.....	48	XELJANZ XR.....	339
TRAZIMERA.....	347	XERMELO.....	323
TRELSTAR INTRAMUSCULAR		XGEVA.....	83
SUSPENSION FOR		XIFAXAN ORAL TABLET 200 MG,	
RECONSTITUTION.....	351	550 MG.....	273
TREMFYA.....	134	XOLAIR.....	231
<i>tretinoin</i> .....	341	XOSPATA.....	129

XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK).....	295
XTANDI ORAL CAPSULE.....	106
XTANDI ORAL TABLET 40 MG, 80 MG.....	106
XYOSTED.....	329
XYREM.....	300
YERVOY.....	169
YONSA.....	9
ZARXIO.....	120
ZEJULA.....	220
ZELBORAF.....	360
ZIRABEV.....	44
ZOLADEX.....	133
ZTALMY.....	127
ZTLIDO.....	191
ZYDELIG.....	159
ZYKADIA.....	60
ZYNLONTA.....	195