



OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

2023 Prior Authorization Criteria

(Requirements for approval for certain drugs)

Please read: This document contains information about the drugs we cover in this plan.

Criterios de autorización previa para 2023

(Requisitos para la aprobación de ciertos medicamentos)

Favor de leer: Este documento contiene información sobre los medicamentos cubiertos en este plan.

Các Tiêu Chuẩn Về Sự Chấp Thuận Trước Trong Năm 2023

(Những yêu cầu để được chấp thuận cho các loại thuốc nhất định)

Vui lòng đọc: Tài liệu này gồm có các thông tin về các loại thuốc chúng tôi đài thọ trong chương trình này.

شرایط دریافت مجوز قبلی برای سال 2023 (شرایط تأیید داروهای خاص)

لطفاً مطالعه کنید: این نوشتار حاوی اطلاعات مهمی درباره داروهایی است که در این برنامه تحت پوشش داریم.

2023 사전 승인 기준

(특정 의약품의 승인 조건)

읽어 주십시오: 본 문서는 본 플랜에서 보장하는 의약품 정보를 포함하고 있습니다.

معايير الحصول على تصريح مسبق لعام 2023 (متطلبات الموافقة على أدوية معينة)

يرجى القراءة: هذه الوثيقة تتضمن معلومات بخصوص الأدوية التي نقوم بتغطيتها في هذه الخطة.

2023年預先授權標準

（特定藥物的批准要求）

請閱讀：本文件包含關於本計劃所承保藥物的資訊。

ABSSSI 2 WEEK

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DALVANCE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

2 weeks

OTHER CRITERIA

Medical justification specifying that oral antibiotics and IV vancomycin have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

ABSSSI 6 DAY

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SIVEXTRO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 days

OTHER CRITERIA

N/A

ACTEMRA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ACTEMRA 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: For rheumatoid arthritis (RA), previous trial of or contraindication to any two of the following preferred agents: Humira, Enbrel, Xeljanz, Rinvoq. For polyarticular juvenile idiopathic arthritis (PJIA), previous trial or contraindication to any TWO of the following: Humira, Enbrel or Xeljanz.

ADHD

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DEXTROAMPHETAMINE 10 MG TAB, DEXTROAMPHETAMINE 5 MG TAB, DEXTROAMPHETAMINE SULFATE ER, DEXTROAMP-AMPHET ER 10 MG CAP, DEXTROAMP-AMPHET ER 15 MG CAP, DEXTROAMP-AMPHET ER 20 MG CAP, DEXTROAMP-AMPHET ER 25 MG CAP, DEXTROAMP-AMPHET ER 30 MG CAP, DEXTROAMP-AMPHET ER 5 MG CAP, DEXTROAMPHETAMINE-AMPHETAMINE, METHYLPHENIDATE, METHYLPHENIDATE ER 10 MG TAB, METHYLPHENIDATE ER 18 MG TAB, METHYLPHENIDATE ER 20 MG TAB, METHYLPHENIDATE ER 27 MG TAB, METHYLPHENIDATE ER 36 MG TAB, METHYLPHENIDATE ER 54 MG TAB, METHYLPHENIDATE ER 72 MG TAB, METHYLPHENIDATE ER (LA), METHYLPHENIDATE 10 MG TABLET, METHYLPHENIDATE 10 MG/5 ML SOL, METHYLPHENIDATE 20 MG TABLET, METHYLPHENIDATE 5 MG TABLET, METHYLPHENIDATE 5 MG/5 ML SOLN, METHYLPHENIDATE HCL CD, METHYLPHENIDATE HCL ER (CD), METHYLPHENIDATE LA, METHYLPHENIDATE SR

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

If the patient is receiving concomitant sedatives (ramelteon, zaleplon, zolpidem) or benzodiazepines (alprazolam, chlordiazepoxide, clobazam, clonazepam, diazepam, estazolam, flurazepam, lorazepam, oxazepam, quazepam, temazepam, triazolam), justification as to why both agents are medically

necessary.

ADLARITY

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ADLARITY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying why rivastigmine patch and donepezil tablet cannot not be used.

AEMCOLO

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

AEMCOLO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 days

OTHER CRITERIA

Medical justification that two formulary alternatives (Azithromycin, Ciprofloxacin, Levofloxacin) have been tried and failed or are contraindicated, or would not be medically appropriate for the patient.

ALINIA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NITAZOXANIDE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information documenting infection with giardia or cryptosporidium species

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

2 weeks

OTHER CRITERIA

For treatment of giardiasis: medical justification specifying why tinidazole could not be used.

AMIKACIN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ARIKAYCE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

Documented failure with a multidrug background regimen therapy.

ANDROGENS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

METHYLTESTOSTERONE, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 25 MG/2.5 GM PKT, TESTOSTERONE 30 MG/1.5 ML PUMP, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, TESTOSTERONE 10 MG GEL PUMP, TESTOSTERON CYP 1,000 MG/10 ML, TESTOSTERON CYP 2,000 MG/10 ML, TESTOSTERONE CYP 1,000 MG/10ML, TESTOSTERONE CYP 1,000 MG/5 ML, TESTOSTERONE CYP 100 MG/ML, TESTOSTERONE CYP 2,000 MG/10ML, TESTOSTERONE CYP 200 MG/ML, TESTOSTERONE CYP 500 MG/2.5 ML, TESTOSTERONE CYP 500 MG/5 ML, TESTOSTERONE CYP 6,000 MG/30ML, TESTOSTERONE ENANTHATE

EXCLUSION CRITERIA

Testosterone levels within normal range (range for the lab doing the testing). Female patients (except for palliation of inoperable metastatic (skeletal) mammary cancer or gender dysphoria). Men with carcinoma of the breast or suspected carcinoma of the prostate. Use to enhance athletic ability.

REQUIRED MEDICAL INFORMATION

For patients initiating testosterone replacement therapy: Testosterone levels (total or free) within the previous 3 months. Require either ONE low total testosterone level OR ONE low free testosterone level. (normal ranges as provided by office or clinic performing labs).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Maximum recommended daily dosage.

ANTIBACTERIALS, OTHER BROAD-SPECTRUM

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

AVYCAZ, LINEZOLID, LINEZOLID-D5W, TEFLARO, TIGECYCLINE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 weeks

OTHER CRITERIA

Medical justification specifying that one formulary antibacterial indicated for the respective diagnosis within the listed antibacterial class of beta lactams, macrolides, fluoroquinolones, aminoglycosides or glycopeptides has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

ANTICGRP

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

AIMOVIG AUTOINJECTOR, AJOVY AUTOINJECTOR, AJOVY SYRINGE, EMGALITY 300 MG (100 MG X 3 SYRINGE), EMGALITY PEN, EMGALITY SYRINGE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Patient must have at least 4 migraine days per month. Patient must have an inadequate response, contraindication, or intolerance to two different migraine prevention therapies from different classes such as antiepileptics (divalproex, topiramate, valproate, gabapentin, carbamazepine), beta blockers (propranolol, metoprolol, timolol, atenolol, nadolol), antidepressants (amitriptyline, nortriptyline, venlafaxine), calcium channel blocker (nicardipine, verapamil), angiotensin receptor II blockers ARB/Angiotensin-converting enzyme inhibitors (ACEIs) (candesartan, lisinopril) or antihistamine (cyproheptadine). For treatment of episodic cluster headache, patient must have an inadequate response, contraindication, or intolerance to at least one triptan (subcutaneous or intranasal sumatriptan) and dihydroergotamine. Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

ANTIFUNGAL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ABELCET, AMBISOME, AMPHOTERICIN B LIPOSOME, CASPOFUNGIN ACETATE, ERAXIS (WATER DILUENT), POSACONAZOLE 200 MG/5 ML SUSP, POSACONAZOLE DR 100 MG TABLET, VORICONAZOLE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Excluded under Part D if meets coverage criteria under Part B.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Medical justification specifying that one applicable formulary alternative (Oral Clotrimazole, Oral Fluconazole, Oral Flucytosine, Griseofulvin, Oral Itraconazole, Oral Ketoconazole, Oral Nystatin, or Oral Terbinafine) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

ANTINAUSEA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

APREPITANT, GRANISETRON HCL 1 MG TABLET

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Medical justification specifying that one applicable formulary alternative (Metoclopramide, Ondansetron, Tetrahydrocannabinol [Dronabinol]) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

ANTINEOPLASTICS

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ALECENSA, ALUNBRIG, BALVERSA, BESREMI, BOSULIF, CALQUENCE, COMETRIQ, COPIKTRA, DAURISMO, ERLOTINIB HCL, EXKIVITY, FIRMAGON, FOTIVDA, GAVRETO, GEFITINIB, GILOTRIF, ICLUSIG, IDHIFA, IMATINIB MESYLATE, INLYTA, INQOVI, INREBIC, JAYPIRCA, KOSELUGO, KRAZATI, LAPATINIB, LENALIDOMIDE, LONSURF, LORBRENA, LUMAKRAS, NERLYNX, ODOMZO, OJJAARA, ONUREG, ORSERDU, PAZOPANIB HCL, PEMAZYRE, PIQRAY, QINLOCK, RETEVMO, REZLIDHIA, ROZLYTREK 100 MG CAPSULE, ROZLYTREK 200 MG CAPSULE, SCEMBLIX, SORAFENIB, SPRYCEL, STIVARGA, SUNITINIB MALATE, SYNRIBO, TAGRISSO, TALZENNA, TASIGNA, TAZVERIK, TEPMETKO, TIBSOVO, TOREMIFENE CITRATE, TUKYSA, TURALIO 125 MG CAPSULE, VANFLYTA, VENCLEXTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VOTRIENT, WELIREG, XALKORI 200 MG CAPSULE, XALKORI 250 MG CAPSULE, XOSPATA, XPOVIO, XTANDI, ZEJULA 100 MG TABLET, ZEJULA 200 MG TABLET, ZEJULA 300 MG TABLET, ZYDELIG, ZYKADIA 150 MG TABLET

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology.

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

ANTINEOPLASTICS-MULTI

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ABIRATERONE ACETATE, AYVAKIT, BRAFTOVI 75 MG CAPSULE, COTELLIC, ERLEADA, EVEROLIMUS 10 MG TABLET, EVEROLIMUS 2 MG TAB FOR SUSP, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 3 MG TAB FOR SUSP, EVEROLIMUS 5 MG TAB FOR SUSP, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, FLUOROURACIL 0.5% CREAM, FLUOROURACIL 2% TOPICAL SOLN, FLUOROURACIL 5% CREAM, FLUOROURACIL 5% TOPICAL SOLN, GLEOSTINE, IMBRUVICA 140 MG CAPSULE, IMBRUVICA 140 MG TABLET, IMBRUVICA 280 MG TABLET, IMBRUVICA 420 MG TABLET, IMBRUVICA 70 MG CAPSULE, IMBRUVICA 70 MG/ML SUSPENSION, JAKAFI, LYTGobi, MEKINIST, MEKTOVI, NUBEQA, ORGOVYX, TAFINLAR, VALCHLOR, YONSA, ZELBORAF

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

APTIOM

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

APTIOM

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification must be received why Formulary Alternatives carbamazepine or oxcarbazepine cannot be used.

ATYPICALS

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ASENAPINE MALEATE, CAPLYTA, FANAPT, LYBALVI, REXULTI 0.25 MG TABLET, REXULTI 0.5 MG TABLET, REXULTI 1 MG TABLET, REXULTI 2 MG TABLET, REXULTI 3 MG TABLET, REXULTI 4 MG TABLET, SECUADO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Medical justification specifying that two formulary alternatives (aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Psychiatry

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

AURYXIA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

AURYXIA

EXCLUSION CRITERIA

Iron overload syndromes, Normal phosphorus level for new starts, PTH is not elevated for new starts.

REQUIRED MEDICAL INFORMATION

Labs including Calcium, Phosphate, Albumin drawn within the past 30 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Nephrology

COVERAGE DURATION

3 months

OTHER CRITERIA

Justification why calcium acetate cannot be used.

AUSTEDO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

AUSTEDO, AUSTEDO XR, AUSTEDO XR TITRATION KT(WK1-4)

EXCLUSION CRITERIA

Concurrent use of monoamine oxidase inhibitors (i.e. selegiline, phenelzine, isocarboxazid, or tranylcypromine) or reserpine.

REQUIRED MEDICAL INFORMATION

Chorea associated with Huntington disease- Initial therapy: (1) Documentation confirming diagnosis including motor examination features and genetic testing (i.e. an expanded HTT CAG repeat sequence greater than 36), and (2) Medical justification specifying that the member has tried and failed (due to side effects of tardive dyskinesia, extrapyramidal effects, dysphagia, aspiration pneumonia, or therapy was ineffective), or has a contraindication or intolerance to tetrabenazine. Continuation therapy: Documentation indicating that symptoms have improved or stabilized. Tardive dyskinesia- Initial therapy: (1) Baseline Abnormal Involuntary Movement Scale (AIMS) scores (items 1-7). Continuation therapy: documentation of the current AIMS score showing improvement as compared to baseline AIMS score (decreased number).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Chorea associated with Huntington disease: Neurology.

COVERAGE DURATION

1 year

OTHER CRITERIA

Maximum dose of 48mg per day.

AUVELITY

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

AUVELITY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Documentation or record of the symptoms and duration of the episode. For treatment of depression, the depression rating scale and score are required.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying that two of the formulary alternatives (citalopram, desvenlafaxine, escitalopram, fluoxetine, paroxetine, sertraline or venlafaxine) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

AVYCAZ

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VABOMERE, ZERBAXA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

2 weeks

OTHER CRITERIA

N/A

AZITHROMYCIN 600 MG ORAL TABLET

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

AZITHROMYCIN 600 MG TABLET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification why other strengths cannot be used if the diagnosis is not treatment or prophylaxis of Mycobacterium avium complex (MAC). Up to 1200mg per week for prophylaxis or 600mg per day for treatment.

BAXDELA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

BAXDELA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Infectious Disease

COVERAGE DURATION

14 days

OTHER CRITERIA

Medical justification specifying that two applicable formulary antibacterials in the class of Beta Lactams, Macrolides, Quinolones, Sulfonamides or Tetracyclines have been tried and failed, are contraindicated, or would not be medically appropriate for the patient, or upon hospital discharge.

BENZNIDAZOLE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

BENZNIDAZOLE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Documentation of one of the following: (1) Detection of circulating *T. cruzi* trypomastigotes on microscopy, (2) Detection of *T. cruzi* DNA by polymerase chain reaction assay, or (3) Two positive diagnosis serologic tests using different techniques (e.g., enzyme-linked immunoassay, indirect fluorescent antibody) and antigens (e.g., whole-parasite lysate, recombinant antigens) showing IgG antibodies to *T. cruzi*.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Infectious Disease

COVERAGE DURATION

3 months

OTHER CRITERIA

Dose (weight-based) does not exceed 400mg/day.

BEXAROTENE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

BEXAROTENE 1% GEL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

BRONCHODILATORS, SYMPATHOMIMETIC

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ARFORMOTEROL TARTRATE, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL HCL

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification why a beta agonist inhaler cannot be used.

BRUKINSA

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

BRUKINSA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

1 year

OTHER CRITERIA

Mantle Cell Lymphoma (MCL): The member has a history of failure, contraindication, or reason(s) for intolerance to one prior first line therapy, such as CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone), R-CHOP, B-R (bendamustine and rituximab), R-DHAP (rituximab, dexamethasone, cytarabine, and cisplatin), or VcR-CAP (bortezomib, rituximab, cyclophosphamide, doxorubicin, and prednisone). Marginal Zone Lymphoma (MZL): The member has received at least one prior anti-CD20 based therapy.

BUTALBITAL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

BUTALBITAL-ACETAMINOPHEN-CAFFE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

For enrollees age 65 and over, the prescriber must acknowledge that medication benefits outweigh potential risks. For continuation of care beyond the initial 3 months: Butalbital-acetaminophen-caffeine is not recommended for extended and repeated use. Please provide a medical justification statement as to the need for continued therapy.

CABLIVI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CABLIVI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: (1) Diagnosis of aTTP confirmed with a PLASMIC score of 6 to 7, (2) Prescribed in combination with plasma exchange therapy (PEX), and (3) Prescribed in combination with immunosuppressive therapy (i.e., glucocorticoids, rituximab). COC: (1A) If request is for a new treatment cycle, member has experienced no more than two recurrences while taking Cablivi, and prescribed in combination with plasma exchange and immunosuppressive therapy (i.e., glucocorticoids, rituximab), or (1B) If request is for treatment extension, documentation or record of a positive clinical response to therapy (e.g. improvement in any of the following: increase in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers [lactate dehydrogenase, cardiac troponin I, and serum creatinine]).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology

COVERAGE DURATION

3 months

OTHER CRITERIA

Member cannot receive more than 58 days of Cablivi therapy after completion of plasma exchange therapy.

CABOMETYX

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

CABOMETYX

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For diagnosis of hepatocellular carcinoma (HCC): member has history of failure, contraindication, or reason(s) for intolerance to sorafenib (Nexavar).

CANNABIDIOL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

EPIDIOLEX

EXCLUSION CRITERIA

Age less than 1 years old

REQUIRED MEDICAL INFORMATION

Clinical information provided to support the following: (1) a diagnosis of Lennox-Gastaut syndrome, Dravet syndrome, or Tuberous sclerosis complex, (2) patient will continue treatment with at least one other antiepileptic drug, and (3) patient's weight and labs including AST/ALT and bilirubin levels within the past 30 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

3 months

OTHER CRITERIA

Dose does not exceed 20mg/kg/day.

CARBAGLU

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CARGLUMIC ACID

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Laboratory results which confirm the diagnosis, such as enzyme analysis of liver biopsy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

CENEGERMIN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

OXERVATE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Clinical information to support diagnosis of neurotrophic keratitis. COC: clinical information to indicate complete or improved corneal healing.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Ophthalmology

COVERAGE DURATION

8 weeks

OTHER CRITERIA

Dose does not exceed 1 vial per affected eye per day.

CHOLBAM

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CHOLBAM

EXCLUSION CRITERIA

Used to treat extrahepatic manifestations (such as but not limited to neurologic symptoms) of single enzyme defect-associated bile acid synthesis disorders or peroxisomal disorders.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 3 months. Continuation: 1 year

OTHER CRITERIA

For initial therapy: (A) Diagnosis of bile acid synthesis disorders (BASDs) due to single enzyme defects (SEDs) including but not limited to 3 beta-hydroxy-delta 5-C27-steroid oxidoreductase defects OR (B) Diagnosis of peroxisomal disorders (PDs) including but not limited to Zellweger spectrum disorders AND (C) Individual has one of the following: (a) Manifestations of liver disease (for example, jaundice, hepatomegaly) (b) steatorrhea (c) Complications from decreased fat soluble vitamin (such as but not limited to vitamin D and K) absorption (for example, rickets, hypocalcemia, bleeding). For maintenance therapy: Meets the initial request criteria AND has had a clinical improvement (symptoms, lab values) in liver function and/or cholestasis AND has not developed a complete biliary obstruction.

CIMZIA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CIMZIA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area. Non-radiographic axial spondyloarthritis: patient has one of the following objective signs of inflammation: 1) C-reactive protein (CRP) levels above the upper limit of normal or 2) sacroiliitis on magnetic resonance imaging (MRI).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Rheumatoid arthritis (RA): previous trial of or contraindication to any two of the following preferred agents: Humira, Enbrel, Xeljanz, Rinvoq. Psoriatic arthritis (PSA) previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Xeljanz, Rinvoq, Skyrizi. Plaque psoriasis (PSO): previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Skyrizi. Ankylosing spondylitis (AS): previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Enbrel, Rinvoq, or Xeljanz. Crohns disease (CD): previous trial of or contraindication to Humira and Stelara. Non-Radiographic Axial Spondyloarthritis (NR-SpA): previous trial of or contraindication to Cosentyx. Patients who are pregnant, breastfeeding, or trying to become pregnant are excluded from step criteria for all indications.

CORLANOR

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CORLANOR

EXCLUSION CRITERIA

Individual has a heart rate maintained exclusively by a pacemaker. Individual has severe hypotension (blood pressure less than 90/50 mmHg). Individual has severe hepatic impairment (Child-Pugh Class C).

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Cardiology

COVERAGE DURATION

1 year

OTHER CRITERIA

Individual is using for the treatment of New York Heart Association (NYHA) class II, III or IV heart failure symptoms

CORTICOTROPIN

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ACTHAR, CORTROPHIN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For all indications except infantile spasms, documentation of limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (e.g. IV methylprednisolone, IV dexamethasone, or high dose oral steroids).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurologist for infantile spasm

COVERAGE DURATION

Multiple sclerosis: 21 days. Other approved indications: 28 days.

OTHER CRITERIA

For acute exacerbations of multiple sclerosis (MS), patients must be receiving concurrent immunomodulator therapy (e.g. interferon beta 1a, glatiramer acetate, dimethyl fumarate, fingolimod, or teriflunomide). For proteinuria in nephrotic syndrome, trial/failure or contraindication to calcineurin inhibitors (e.g. cyclosporine or tacrolimus) must be documented. For gout, an intolerance or contraindication to at least two first-line gout therapies (e.g. allopurinol, probenecid, or colchicine) must be documented. For continuation of care beyond the initial 28 days, medical documentation is required demonstrating positive effectiveness. Part B before Part D Step Therapy.

Part B Prerequisite Required

COSENTYX

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

COSENTYX (2 SYRINGES), COSENTYX SENSOREADY (2 PENS), COSENTYX SENSOREADY PEN, COSENTYX SYRINGE, COSENTYX UNOREADY PEN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Moderate to severe psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial for plaque psoriasis: previous trial of or contraindication to at least one conventional therapy such as PUVA (phototherapy ultraviolet light A), UVB (ultraviolet light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. Psoriatic arthritis: previous trial of or contraindication to at least one DMARD (disease-modifying anti-rheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.

CROFELEMER

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

MYTESI

EXCLUSION CRITERIA

Infectious diarrhea

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

Medical justification specifying why a formulary alternatives loperamide or diphenoxylate-atropine cannot be used.

CSF

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

FULPHILA, FYLNETRA, GRANIX, LEUKINE, NEULASTA, NEUPOGEN, NIVESTYM, NYVEPRIA, RELEUKO 300 MCG/0.5 ML SYRINGE, RELEUKO 480 MCG/0.8 ML SYRINGE, STIMUFEND, UDENYCA, UDENYCA AUTOINJECTOR, ZARXIO, ZIEXTENZO

EXCLUSION CRITERIA

Neutrophil count higher than 100,000/mm³.

REQUIRED MEDICAL INFORMATION

Patient's weight, CBC with differential drawn within the past 2 weeks.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

If any of the following is true, CSFs will be covered only if additional medical documentation establishes medical necessity in the individual case: (1) the neutrophil count is higher than 1,000/mm³ in patients with neutropenia other than chemotherapy-induced, (2) the neutrophil count is higher than 5,000/mm³ in patients receiving myelosuppressive chemotherapy, or (3) Filgrastim: dosing exceeds 10mcg/kg.

DAE SFU

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

GLIMEPIRIDE, GLYBURIDE, GLYBURIDE-METFORMIN HCL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Prescriber must acknowledge that medication benefits outweigh potential risks in patients 67 years of age or older.

AGE RESTRICTION

PA required for enrollees age 67 and over. No PA required for enrollees under age 67.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Medical justification specifying that at least two formulary alternatives without age restrictions (glipizide or non-sulfonylurea agents) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

DAE SLEEP DRUGS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE 10 MG TABLET, ZOLPIDEM TARTRATE 5 MG TABLET, ZOLPIDEM TARTRATE ER

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Prescriber must acknowledge that medication benefits outweigh potential risks in patients 67 years of age or older.

AGE RESTRICTION

PA required for enrollees age 67 and over. No PA required for enrollees under age 67.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Medical justification specifying that at least two formulary alternatives without age restrictions (Ramelteon, Trazodone, Lorazepam, Oxazepam) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

DALIRESP

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DALIRESP 500 MCG TABLET, ROFLUMILAST

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Individual is currently or will be concomitantly using with a long-acting bronchodilator.

DEMECLOCYCLINE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

DEMECLOCYCLINE HCL

EXCLUSION CRITERIA

Drug-induced SIADH.

REQUIRED MEDICAL INFORMATION

Labs including eGFR, and SCr, drawn within the past 90 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Drug-induced SIADH should be treated by withdrawal of the offending drug and fluid restriction. Medical justification criteria must be provided including why a formulary alternative such as furosemide cannot be used.

DERMATITIS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PIMECROLIMUS, TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Medical justification as to why topical corticosteroids cannot be used.

DERMATOLOGICAL AGENTS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

AVITA 0.025% CREAM, DICLOFENAC SODIUM 3% GEL, DOXEPIN 5% CREAM, TAZAROTENE 0.05% GEL, TAZAROTENE 0.1% GEL, TAZORAC 0.05% CREAM, TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.05% GEL, TRETINOIN 0.1% CREAM

EXCLUSION CRITERIA

Cosmetic use.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

DIAGNOSTIC USE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ATROPINE 1% EYE DROPS

EXCLUSION CRITERIA

Diagnostic use

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

DIALYSIS-PTH

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

FOSRENOL 1,000 MG POWDER PACK, FOSRENOL 750 MG POWDER PACKET, LANTHANUM CARBONATE

EXCLUSION CRITERIA

Normal phosphorus level for new starts, patient is not receiving dialysis, PTH is not elevated for new starts.

REQUIRED MEDICAL INFORMATION

Labs including Calcium, Phosphate, Albumin drawn within the past 30 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Nephrology

COVERAGE DURATION

3 months

OTHER CRITERIA

Justification why calcium acetate cannot be used.

DICLOFENAC

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DICLOFENAC EPOLAMINE, DICLOFENAC 2% SOLUTION PUMP

EXCLUSION CRITERIA

Myocardial infarction (MI) or coronary artery bypass graft (CABG) in the previous year.

REQUIRED MEDICAL INFORMATION

New: Documentation or record that diclofenac 1% gel has been tried and failed within the previous 6 months. Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

Statement of medical justification for concomitant therapy with another nonsteroidal anti-inflammatory drug (NSAID). For continued therapy beyond 6 months, documented evaluation for gastrointestinal (GI) adverse events.

DIRECT RENIN INHIBITOR

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ALISKIREN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying that two applicable formulary angiotensin II receptor antagonists (ARBs) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

DOJOLVI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DOJOLVI

EXCLUSION CRITERIA

Concomitant use with other medium-chain triglyceride products.

REQUIRED MEDICAL INFORMATION

New: Patient has a molecularly confirmed diagnosis of a long-chain fatty acid oxidation disorder based on: (1) Disease-specific elevations of acylcarnitines on a newborn blood spot or in plasma, (2) Enzyme activity assay (in cultured fibroblasts or lymphocytes) below the lower limit of the normal reference range for the reporting laboratory, or (3) Genetic testing demonstrating pathogenic mutation in a gene associated with long-chain fatty acid oxidation disorders. COC: Documentation of positive clinical response to therapy (e.g., increased cardiac efficiency, decreased left ventricular wall mass, decreased incidence of rhabdomyolysis, etc.).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

DOPTELET

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

DOPTELET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Platelet Count (Drawn within last 30 days) indicating platelets less than $50 \times 10^9/L$.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

For treatment of thrombocytopenia in patients with chronic liver disease: documentation or record of a planned medical or dental procedure within 10-13 days after starting Doptelet. This requirement does not apply for the treatment of other approved indications.

DRY EYE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

CYCLOSPORINE 0.05% EYE EMULS, EYSUVIS, LACRISERT, XIIDRA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Documentation is provided indicating an abnormal result or response to one or more of the following dry eye disease diagnostic/assessment methods (AAO, 2013): (a) Tear break-up time (less than 10 seconds) OR (b) Ocular surface dye staining using fluorescein, rose bengal, or lissamine green dyes OR (c) Schirmer test (aqueous tear production of less than or equal to 10 mm of strip wetting in 5 minutes) OR (d) Fluorescein clearance test/tear function index OR (e) Tear osmolarity (indicating tear film instability) OR (f) Tear lactoferrin concentrations in the lacrimal gland (decreased).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Cyclosporine, Lacrisert, and Xiidra: 1 year, Eysuvis: 2 weeks

OTHER CRITERIA

Individual is using to treat moderate to severe dry eye disease (AAO 2013).

DUPIXENT

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DUPIXENT PEN, DUPIXENT SYRINGE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For treatment of atopic dermatitis (AD): Body surface area (BSA) involvement equal to or greater than 10 percent OR Eczema Area and Severity Index (EASI) score of 16 or greater OR affecting crucial body areas such as the hands, feet, face, or genitals. For Eosinophilic esophagitis (EoE): Diagnosis confirmed by esophagogastroduodenoscopy (EGD) with biopsy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

For AD (in patients 2 years and older): Member must have tried and failed or have a contraindication or intolerance to a generic formulary topical corticosteroid and generic topical tacrolimus. PN: 1) Chronic pruritis (more 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). For renewal: AD: Members condition is stable or showing clinical improvement. EOE: Improvement while on therapy. PN: Improvement or reduction of pruritis or pruriginous lesions.

EGRIFTA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

EGRIFTA SV

EXCLUSION CRITERIA

1. Active malignancy. 2. Disruption of the hypothalamic-pituitary axis (due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, head irradiation or trauma). 3. Pregnancy. 4. Weight loss management

REQUIRED MEDICAL INFORMATION

Documentation of active antiretroviral therapy (at least 8 weeks). Baseline visceral adipose tissue (VAT), waist circumference, waist to hip ratio, fasting blood glucose, and body mass index (BMI) are required. For continuation therapy, current VAT is also required.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 3 months. Continuation: 6 months.

OTHER CRITERIA

For initial therapy: Waist circumference greater than or equal to 37 inches (94 cm), waist to hip ratio greater than or equal to 0.94 for men or 0.88 for women, fasting blood glucose less than 150 mg/dL, and BMI greater than 20 kg/m². For continuation, individual must demonstrate there is a clear response in reduction of visceral adipose tissue measured by waist circumference or computed tomography (CT) scan.

EMFLAZA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

EMFLAZA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Documentation indicating a diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with Neurology

COVERAGE DURATION

Initial: 6 months. Continuation: 1 year

OTHER CRITERIA

Member must have tried and failed or have a contraindication or intolerance to Prednisone. Requested dose does not exceed 0.9mg/kg/day. For continuation: documentation of positive response to therapy (i.e. improved muscle strength or pulmonary function).

ENBREL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ENBREL 25 MG/0.5 ML SYRINGE, ENBREL 25 MG/0.5 ML VIAL, ENBREL 50 MG/ML SYRINGE, ENBREL MINI, ENBREL SURECLICK

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Moderate to severe psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Rheumatoid arthritis: previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.

ENSPRYNG

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ENSPRYNG

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Clinical information provided showing (1) ONE of the following: Optic neuritis, Acute myelitis, Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting, Acute brainstem syndrome, Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions and (2) positive for the anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies. COC: (1) Documentation showing a positive response from baseline such as reduction in the number and/or severity of relapses, reduction in signs and symptoms of NMOSD, or reduction/discontinuation of corticosteroid or other supportive therapies.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

History of greater than or equal to 1 relapses during the previous 12 months

ENZYME REPLACEMENTS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CYSTAGON, JAVYGTOR, MIGLUSTAT, RAVICTI, SAPROPTERIN DIHYDROCHLORIDE, SODIUM PHENYLBUTYRATE POWDER, YARGESA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

EPCLUSA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

EPCLUSA 150-37.5 MG PELLETT PKT, EPCLUSA 200 MG-50 MG TABLET, EPCLUSA 200-50 MG PELLETT PACK, SOFOSBUVIR-VELPATASVIR

EXCLUSION CRITERIA

Patients concurrently using any of the following medications not recommended by the manufacturer: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, efavirenz (e.g. ATRIPLA, SUSTIVA), rosuvastatin at doses greater than 10mg daily, tipranavir/ritonavir, or topotecan.

REQUIRED MEDICAL INFORMATION

HCV RNA level within past 6 months. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA

Criteria will be applied consistent with current AASLD/IDSA guidance. HCV RNA level within the past 6 months. Combination therapy with ribavirin is required for patients with decompensated cirrhosis, unless the patient is ribavirin ineligible.

EPO

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ARANESP 10 MCG/0.4 ML SYRINGE, ARANESP 100 MCG/0.5 ML SYRINGE, ARANESP 100 MCG/ML VIAL, ARANESP 150 MCG/0.3 ML SYRINGE, ARANESP 200 MCG/0.4 ML SYRINGE, ARANESP 200 MCG/ML VIAL, ARANESP 25 MCG/0.42 ML SYRING, ARANESP 25 MCG/ML VIAL, ARANESP 300 MCG/0.6 ML SYRINGE, ARANESP 40 MCG/0.4 ML SYRINGE, ARANESP 40 MCG/ML VIAL, ARANESP 500 MCG/1 ML SYRINGE, ARANESP 60 MCG/0.3 ML SYRINGE, ARANESP 60 MCG/ML VIAL, EPOGEN, PROCRIT, RETACRIT

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

Labs including Hgb, Hct, serum ferritin, serum transferrin saturation drawn within the past 60 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Dose reduction or interruption is required if hemoglobin exceeds 10 g/dL (adult CKD not on dialysis, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD).

EXJADE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DEFERASIROX 125 MG TB FOR SUSP, DEFERASIROX 250 MG TB FOR SUSP, DEFERASIROX 500 MG TB FOR SUSP, DEFERIPRONE, DEFERIPRONE (3 TIMES A DAY), FERRIPROX 100 MG/ML SOLUTION

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Current weight, lab values for serum ferritin, SCr, ALT/AST drawn within the past 30 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

3 months

OTHER CRITERIA

Dose cannot exceed 99mg/kg/day for deferiprone or 40mg/kg/day for deferasirox products. For transfusional iron overload: serum ferritin must consistently be greater than 1000 mcg/L.

FASENRA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

FASENRA, FASENRA PEN

EXCLUSION CRITERIA

Current respiratory disease other than asthma. On dual therapy with another monoclonal antibody for the treatment of asthma. Excluded under Part D if meets coverage criteria under Part B. (Syringe will be reviewed under Part B).

REQUIRED MEDICAL INFORMATION

Blood eosinophil at least 150 cells/uL within 4 weeks. New: Documentation or record of persistent airflow obstruction as indicated by 1) pre-bronchodilator FEV1 less than 80% predicted. COC: Baseline blood eosinophil at least 150 cells/uL prior to treatment AND Clinical information documenting that member has experienced a reduction in at least ONE of the following: (1) reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath, (2) decrease in administration of rescue medication, (3) decrease in exacerbation frequency or (4) increase in predicted FEV1 from the pretreatment baseline.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 3 months. Continuation: 1 year

OTHER CRITERIA

New: (1) member has had 1 or more asthma exacerbations in the past 12 months requiring corticosteroid treatment and (2) clinical documentation of poor asthma control despite usage of maximal dosages of an inhaled corticosteroid (ICS) or combination ICS with long-acting beta-2 agonist or has documented intolerance or contraindications to ICS or ICS/LABA usage.

FILSPARI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

FILSPARI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Initial: (1) diagnosis confirmed by biopsy, (2) patient has an estimated glomerular filtration rate greater than or equal to 30 mL/min/1.73 m², and (3) patient is at high risk of disease progression, defined by meeting both of the following criteria: a) Patient has proteinuria greater than 1.0 g/day or a urine protein-to-creatinine ratio greater than or equal to 1.5 g/g, and b) Patient has received the maximum or maximally tolerated dose of one Angiotensin converting enzyme (ACE) inhibitor (e.g. enalapril, lisinopril, perindopril, ramipril) or Angiotensin receptor blocker (ARB) (e.g. losartan, olmesartan, valsartan) for greater than or equal to 12 weeks prior to starting Filspari. COC: (1) diagnosis has been confirmed by biopsy, (2) the patient has had a response to therapy (i.e. reduction in proteinuria from baseline), and (3) the patient has an estimated glomerular filtration rate greater than or equal to 30 mL/min/1.73 m².

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Nephrology

COVERAGE DURATION

Initial: 9 months, COC: 1 year

OTHER CRITERIA

N/A

GALAFOLD

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

GALAFOLD

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Documentation or record of in vitro assay data indicating an amenable galactosidase alpha gene (GLA) variant, or (for males) Biochemical assay of alpha-galactosidase (GLA) enzyme activity in leukocytes of less than 20% of normal activity COC: documentation of disease stability or improvement in symptoms.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 3 months. Continuation: 1 year

OTHER CRITERIA

Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta).

GIMOTI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

GIMOTI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Medical justification that oral metoclopramide has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 weeks

OTHER CRITERIA

For COC: documentation or statement from prescriber confirming improvement of gastroparesis symptoms and the absence of tardive dyskinesia symptoms.

GNRH

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ELIGARD 22.5 MG SYRINGE, ELIGARD 30 MG SYRINGE, ELIGARD 45 MG SYRINGE, ELIGARD 7.5 MG SYRINGE, LEUPROLIDE ACETATE, LEUPROLIDE DEPOT, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED 11.25 MG 3MO, LUPRON DEPOT-PED 45 MG 6MO KIT, LUPRON DEPOT-PED 7.5 MG KIT, SYNAREL, TRELSTAR

EXCLUSION CRITERIA

Infertility treatment.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

GROWTH HORMONE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

GENOTROPIN, HUMATROPE 12 MG CARTRIDGE, HUMATROPE 24 MG CARTRIDGE, HUMATROPE 6 MG CARTRIDGE, INCRELEX, NORDITROPIN FLEXPRO, NORDITROPIN FLEXPRO 30 MG/3 ML, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, SKYTROFA, ZOMACTON

EXCLUSION CRITERIA

Coverage is excluded for adults without demonstrated GH deficiency. Coverage is excluded for use to enhance body mass or strength for professional, recreational or social reasons.

REQUIRED MEDICAL INFORMATION

Copies of recent results (within 3 months) from at least one GH stimulation test: Insulin tolerance test or Arginine plus GHRH. Copies of labs with: Dehydroepiandrosterone (DHEA), Thyroid-stimulating hormone (TSH), Thyroid (free T3 and free T4), Follicle-stimulating hormone (FSH), Luteinizing hormone (LH), Insulin-like growth factor (IGF-1), Hemoglobin A1c level, For males: testosterone levels (total and free), For females: estradiol levels. Patient weight.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Maximum recommended daily dose. For initiation of treatment of growth hormone (GH) deficiency in adults, GH deficiency must be demonstrated with at least one of the following: (1) insulin tolerance test (ITT) with serum GH less than 5.1ng/mL, or (2) IGF-I level less than the age-specific lower limit. Must first try Norditropin or provide medical justification why it would not be medically appropriate.

GROWTH HORMONE ANTAGONISTS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SOMAVERT

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Serum IGF-I level drawn within the past 30 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Maximum recommended daily dose. Diagnosis of acromegaly AND a prescriber affirmation statement that member has had an inadequate response to surgery and/or radiation OR that surgery and/or radiation therapy are not an option (such as but not limited to, individual is an inappropriate candidate for surgical or radiation-based therapy).

HAE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

HAEGARDA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information provided documenting the frequency and severity of HAE attacks.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

Dose does not exceed FDA approved dosage.

HARVONI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LEDIPASVIR-SOFOSBUVIR

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

HCV RNA level within past 6 months. Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA

Criteria will be applied consistent with current AASLD/IDSA guidance. No approval for requests where provider attests that patient has life expectancy less than 12 months due to non-liver related comorbid conditions (per AASLD/IDSA treatment guideline recommendation). Patient is not concurrently taking any of the following: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, rosuvastatin, sofosbuvir (as a single agent), or tipranavir/ritonavir.

HBV

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ADEFOVIR DIPIVOXIL, BARACLUDE 0.05 MG/ML SOLUTION, ENTECAVIR, LAMIVUDINE 100 MG TABLET, LAMIVUDINE HBV, VEMLIDY

EXCLUSION CRITERIA

Antiviral treatment is not indicated in patients with inactive chronic hepatitis B (CHB), defined as: HBV DNA undetectable AND EITHER (1) HBsAg negative for greater than 6 months OR (2) HBsAg positive, HBeAg negative, anti-HBe positive and normal ALT.

REQUIRED MEDICAL INFORMATION

For new HBV treatment: baseline HBsAg (greater than 6 months ago) AND HBV DNA, HBsAg, HBeAg, and LFT within 6 months. For continuation HBV treatment: anti-HBe (HBeAb), HBV DNA, HBsAg, HBeAg, and LFT within 6 months. For prophylaxis of HBV reactivation: documentation or record of previous HBV infection and current condition or therapy causing immunosuppression.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

PREFERRED DRUGS: Must have a history of failure, contraindication, or intolerance to entecavir or adefovir before lamivudine HBV is approved. Must have a history of failure, contraindication, or intolerance to Viread (tenofovir) before Vemlidy is approved. Combination therapy will be approved with documented resistance. **SPECIAL POPULATIONS:** Criteria will be applied consistent with AASLD guidelines. This includes hepatitis D virus, coinfection with HIV or HCV, concomitant immunosuppressive therapy, concomitant cytotoxic therapy, virologic failure, transplant (liver or non-liver solid organ), pregnancy, or pediatric. **SYMPTOMATIC ACUTE HEPATITIS (HBsAg positive for less than 6 months):** antiviral treatment is only indicated in patients with acute liver failure or protracted

severe course (defined by total bilirubin greater than 3 mg/dL, direct bilirubin greater than 1.5 mg/dL, INR greater than 1.5, encephalopathy, or ascites).

CHRONIC HEPATITIS B (CHB) TREATMENT DURATION: [1] HBeAg-negative at baseline, treat indefinitely. [2] CHB with cirrhosis, treat indefinitely. [3] For patients with HBeAg positive infection without cirrhosis, discontinue therapy after HBsAg loss or after treatment consolidation (treat persistently normal ALT and undetectable HBV DNA for 12 months or longer after seroconversion to anti-HBe). [4] For continued therapy beyond the recommended duration, medical justification is required documenting the benefit of continued treatment outweighs the risk of discontinuation.

CHB TREATMENT INDICATIONS (HBsAg positive for at least 6 months, without cirrhosis): [A] HBeAg positive, ALT at least 2XULN (ULN for ALT is 35 U/L for males and 25 U/L for females), HBV DNA greater than 20,000 IU/mL, treat. [B] HBeAg positive, ALT at least 2XULN, HBV DNA between 2,000-20,000 IU/mL, evaluate ALT. [C] HBeAg positive, ALT above ULN but below 2XULN, HBV DNA above 2,000 IU/mL, evaluate ALT. [D] HBeAg positive, ALT below ULN, HBV DNA above 20,000 IU/mL, do not treat. [E] HBeAg positive, ALT below ULN, HBV DNA between 2,000-20,000 IU/mL, consider treatment discontinuation. [F] HBeAg negative, ALT at least 2XULN, HBV DNA at least 2,000 IU/mL, treat. [G] HBeAg negative, ALT at least 2XULN, HBV DNA below 2,000 IU/mL, evaluate ALT. [H] HBeAg negative, ALT above ULN but below 2XULN, HBV DNA above or below 2,000 IU/mL, evaluate ALT. [I] HBeAg negative, ALT below ULN, HBV DNA above 2,000 IU/mL, monitor. [J] HBeAg negative, ALT below ULN, HBV DNA below 2,000 IU/mL, do not treat.

EVALUATE ALT: Rule out other causes of ALT elevation and treat if age is greater than 40 years old OR evidence of liver necroinflammation (A3 or higher) or fibrosis (F2 or higher) is identified via noninvasive testing or biopsy.

HEMADY

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

HEMADY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

HETLIOZ

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TASIMELTEON

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: (Non-24 disorder) documentation or record of a diagnosis of Non-24. (SMS) results of genetic testing showing a microdeletion of chromosome 17p11.2. COC: Documentation showing response to therapy (improvement in sleep quality or time)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

New: 6 months. COC: 1 year

OTHER CRITERIA

N/A

HIGH POTENCY ER OPIOID

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

MORPHINE SULF ER 100 MG TABLET, MORPHINE SULF ER 200 MG TABLET, MORPHINE SULFATE ER 100 MG CAP, MORPHINE SULFATE ER 120 MG CAP

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying that pain is intractable (constant and debilitating pain, potent enough to interfere with sleep, and not controlled on other treatments).

HOFH

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

JUXTAPID 10 MG CAPSULE, JUXTAPID 20 MG CAPSULE, JUXTAPID 30 MG CAPSULE,
JUXTAPID 5 MG CAPSULE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Lipid panel, ALT, AST drawn within the past 30 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Must currently take a statin (unless contraindicated) or provide a medical justification as to why its usage would not be medically appropriate (e.g. statin intolerance) for the patient.

HUMIRA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

HUMIRA, HUMIRA PEDIATRIC CROHN'S, HUMIRA PEN, HUMIRA PEN CROHN'S-UC-HS, HUMIRA PEN PSOR-UVEITS-ADOL HS, HUMIRA(CF), HUMIRA(CF) PEDIATRIC CROHN'S, HUMIRA(CF) PEN, HUMIRA(CF) PEN CROHN'S-UC-HS, HUMIRA(CF) PEN PEDIATRIC UC, HUMIRA(CF) PEN PSOR-UV-ADOL HS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, and psoriatic arthritis: previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. Ankylosing spondylitis: previous trial of formulary agents not required. Plaque psoriasis: previous 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. Crohns disease and ulcerative colitis: previous trial of or contraindication to one conventional therapy such as a corticosteroid (i.e., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine.

HYFTOR

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

HYFTOR

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Definitive diagnosis of tuberous sclerosis complex by meeting one of the following: 1) Identification of a pathogenic variant in the tuberous sclerosis complex 1 (TSC1) gene or tuberous sclerosis complex 2 (TSC2) gene by genetic testing, or 2) Clinical diagnostic criteria suggest a definitive diagnosis of tuberous sclerosis complex by meeting either two major features or one major feature with two minor features. (Major features- angiofibroma or fibrous cephalic plaque, angiomyolipomas, cardiac rhabdomyoma, hypomelanotic macules, lymphangiomyomatosis, multiple cortical tubers and/or radial migration lines, multiple retinal hamartomas, Shagreen patch, subependymal giant cell astrocytoma, subependymal nodule, or ungula fibromas. Minor feature criteria involve “confetti” skin lesions, dental enamel pits (three or more), intraoral fibromas, multiple renal cysts, nonrenal hamartomas, retinal achromic patch, and sclerotic bone lesions).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Dermatology

COVERAGE DURATION

New: 3 months. COC: 1 year.

OTHER CRITERIA

COC: Documentation or statement from prescriber confirming positive clinical response to therapy (e.g., improvement in skin lesions)

IBS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

MOVANTIK

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Medical justification for the concomitant use of antidiarrheals or non-opioid constipating medications.
Medical justification as why bulk or osmotic laxatives are not appropriate. For opioid-induced constipation, clinical information indicating concurrent opioid use.

ILUMYA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ILUMYA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Moderate to severe psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Plaque psoriasis: previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Stelara, Enbrel, Skyrizi.

INTRAROSA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

INTRAROSA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Medical justification specifying that formulary alternatives without age restrictions (e.g. estradiol 0.01% cream, or estradiol/yuvafem vaginal tablet) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

ISTURISA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ISTURISA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: (1) Clinical information indicating pituitary surgery is not an option or has not been curative and (2) baseline 24-hour urinary free cortisol (UCF) level. COC: Labs within past 30 days documenting 24-hour urinary free cortisol (UFC) level has decreased from baseline.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Endocrinology

COVERAGE DURATION

6 months

OTHER CRITERIA

Medical justification specifying that pasireotide has been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

IVIG

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

BIVIGAM, FLEBOGAMMA DIF 10% VIAL, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAKED 1 GRAM/10 ML VIAL, GAMMAPLEX, GAMUNEX-C 1 GRAM/10 ML VIAL, OCTAGAM, PANZYGA, PRIVIGEN

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B (primary immunodeficiency disease).

REQUIRED MEDICAL INFORMATION

Prescribed dose and dosing frequency. Patient's weight and weight-based dose.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Medical justification must be provided to support the prescribed dosage if it exceeds the FDA-approved maximum daily dose.

IXAZOMIB

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

NINLARO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

1 year

OTHER CRITERIA

The member is (1) Using concomitant therapy with lenalidomide (Revlimid) and dexamethasone, (2) Has previously received at least one of the following Immunomodulators (e.g. lenalidomide (Revlimid), pomalidomide (Pomalyst), or thalidomide (Thalomid)), Liposomal doxorubicin (Doxil), cyclophosphamide (Cytoxan), melphalan (Alkeran), or Panobinostat (Farydak), Corticosteroids (e.g. dexamethasone, prednisone) or Radiation, and (3) Has a history of failure, contraindication, or reason(s) for intolerance to bortezomib (Velcade).

JADENU

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DEFERASIROX 180 MG TABLET, DEFERASIROX 360 MG TABLET, DEFERASIROX 90 MG TABLET

EXCLUSION CRITERIA

Dosing not to exceed the 28 mg/kg/day recommendations. Jadenu is contraindicated in patients with serum creatinine greater than 2 times the age-appropriate ULN or CrCl less than 40 mL/min, poor performance status, high-risk myelodysplastic syndromes, advanced malignancies, and platelet counts less than $50 \times 10^9/L$.

REQUIRED MEDICAL INFORMATION

Current weight, lab values drawn within the past 30 days for serum ferritin level, CPT score/class, serum creatinine, platelet count, and ALT/AST. For transfusional iron overload (transfusional hemosiderosis), also provide the length of time on blood transfusions, and date of last blood transfusion. For non-transfusion dependent thalassemia syndromes, also provide liver iron concentration (LIC).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

6 months

OTHER CRITERIA

Serum ferritin must consistently be greater than 1000 mcg/L for transfusional iron overload. Serum ferritin must consistently be greater than 300 mcg/L for non-transfusion-dependent thalassemia syndromes. Dose cannot exceed 28mg/kg/day.

JYNARQUE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

JYNARQUE, TOLVAPTAN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For Jynarque: New therapy- documentation or record of a diagnosis of ADPKD, labs including LFTs and bilirubin in the past 30 days and presence of at least 2 risk factors associated with rapidly progressing disease such as a total kidney volume (TKV) of 750 mL or more, hypertension, presence of PKD1 gene, onset of ADPKD symptoms before the age of 30, presence of proteinuria as indicated by labs, high urinary sodium excretion as indicated by labs or increased fibroblast growth factor (FGF) 23. COC- Labs including LFTs and bilirubin in the past 90 days. For tolvaptan generic: (1) medication is for continuation of care post hospital discharge (2) documentation confirming the diagnosis of hyponatremia such as serum sodium less than 125 mEq/L or less than 135 mEq/L and symptomatic (i.e. headache, nausea, vomiting, fatigue, gait disturbances or confusion) and (4) not currently receiving a strong CYP3A4 inhibitor per claims (clarithromycin, ketoconazole oral, itraconazole, ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, or telithromycin)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Nephrology

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

KALYDECO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

KALYDECO

EXCLUSION CRITERIA

Patients who are homozygous for the F508del mutation in the CFTR gene

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Pulmonology

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

KERENDIA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

KERENDIA

EXCLUSION CRITERIA

Concomitant use with a strong CYP3A4 inhibitor or diagnosis of adrenal insufficiency

REQUIRED MEDICAL INFORMATION

New: (1) Labs within the past 30 days documenting serum potassium level of less than or equal to 5.0 mEq/L, estimated glomerular filtration rate of at least 25 mL/min/1.73m² and urine albumin-to-creatinine ratio (UACR) of at least 30 mg/g (2) Receiving concurrent therapy with angiotensin-converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB) at maximally tolerated labeled dosage, unless contraindicated (3) medical justification that a sodium-glucose cotransport-2 (SGLT2) inhibitor (Jardiance, Invokana, Farxiga, Steglatro) AND a steroidal mineralocorticoid receptor antagonist (spironolactone, eplerenone) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient. COC: (1) Labs within the past 30 days documenting serum potassium level 5.5 mEq/L or less and estimated glomerular filtration rate of at least 25 mL/min/1.73m² and (2) approved prior authorization on file or lab showing UACR of at least 30 mg/g within past 30 days and (3) Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 3 months. COC: 1 year

OTHER CRITERIA

N/A

KEVZARA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

KEVZARA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: For rheumatoid arthritis (RA), previous trial of or contraindication to any two of the following preferred agents: Humira, Enbrel, Xeljanz, Rinvoq.

KINERET

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

KINERET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Rheumatoid arthritis (RA): previous trial of or contraindication to any two of the following preferred agents: Humira, Rinvoq, Enbrel, Xeljanz.

KORLYM

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

KORLYM

EXCLUSION CRITERIA

Pregnancy

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

KRISTALOSE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

KRISTALOSE, LACTULOSE 10 GM PACKET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Medical justification why lactulose solution cannot be used.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

LENVIMA

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

LENVIMA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For renal cell carcinoma (RCC): (1) Lenvima is being used in combination with pembrolizumab or (2) Lenvima is being used in combination with everolimus (Afinitor) and the member has a history of failure, contraindication, or reason(s) for intolerance to one anti-angiogenic therapy such as axitinib (Inlyta), bevacizumab (Avastin), everolimus (Afinitor), pazopanib (Votrient), sorafenib (Nexavar), or sunitinib (Sutent).

LEPTIN

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

MYALEPT

EXCLUSION CRITERIA

1) HIV related lipodystrophy. 2) Metabolic disease, without concurrent evidence of generalized lipodystrophy. 3) General obesity.

REQUIRED MEDICAL INFORMATION

Documentation or record of congenital or acquired generalized lipodystrophy. Weight and height, or BMI.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Endocrinology

COVERAGE DURATION

6 months

OTHER CRITERIA

N/A

LEVORPHANOL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LEVORPHANOL TARTRATE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Clinical information specifying that two applicable formulary alternative short-acting opioid/opioid analgesic combinations (morphine IR, oxycodone, hydromorphone, hydrocodone, oxymorphone) have been tried and failed, is contraindicated, or would not be medically appropriate for the patient in the past 6 months.

LINACLOTIDE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LINZESS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification for the concomitant use of antidiarrheals or non-opioid constipating medications.
Medical justification as why bulk or osmotic laxatives are not appropriate. For opioid-induced constipation, clinical information indicating concurrent opioid use.

LOFEXIDINE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LUCEMYRA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

(1) Diagnosis of opioid use disorder as per DSM-5 criteria, (2) statement from the prescriber that the patient is currently undergoing abrupt opioid discontinuation within the next 7 days, (3) medical justification supporting why an opioid taper with buprenorphine could not be used, and (4) medical records or statement from the prescriber indicating patient will not be using opioid medications during withdrawal period.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved for 14 days of treatment.

OTHER CRITERIA

One of the following must be provided: (1) lofexidine has already been initiated in an inpatient/ER setting or (2) medical justification for why clonidine could not be used. Maximum dosage does not exceed 16 tablets (2.88 mg) daily.

LYRICA

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

PREGABALIN ER

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For neuropathic pain associated with diabetic peripheral neuropathy (DPN), individual had a trial of one of the following: (1) SNRI (such as, Cymbalta (duloxetine HCl) or venlafaxine, (2) Tricyclic antidepressants (such as, amitriptyline, desipramine, nortriptyline), OR (3) Gabapentin. For post herpetic neuralgia, member had a trial of one of the following: (1) Gabapentin (2) Lidocaine patch (Lidoderm) or (3) Tricyclic antidepressants (such as, amitriptyline, desipramine, nortriptyline).

MANNITOL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

BRONCHITOL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Documentation indicating that the member has passed the Bronchitol Tolerance Test (BTT).

COC: Documentation showing response to therapy (improvement in lung function as determined by change in FEV1).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

MAVACAMTEN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CAMZYOS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: The member has 1) left ventricular ejection fraction (LVEF) of greater than or equal to 55%, 2) Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or after provocation, 3) NYHA class II or III symptoms of heart failure, 4) therapeutic failure or intolerance to ONE of the following: Non-vasodilating beta blocker (e.g., metoprolol, propranolol, atenolol) OR Non-dihydropyridine calcium channel blocker (e.g., verapamil, diltiazem). COC: Documentation of positive clinical response to therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Cardiology

COVERAGE DURATION

1 year

OTHER CRITERIA

Dose does not exceed 15 mg per day.

MAVENCLAD

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

MAVENCLAD

EXCLUSION CRITERIA

1) Current malignancy, 2) Pregnant women, 3) HIV infection, 4) Active chronic infections (e.g. hepatitis or tuberculosis).

REQUIRED MEDICAL INFORMATION

First treatment course: Baseline liver function test (LFTs) and complete blood count (CBC) with differential, including lymphocyte counts within normal limits must be provided. Second treatment course: Member has received one course treatment (1.75mg/kg) with Mavenclad 12 months ago, Liver function test (LFTs) and complete blood count (CBC) with differential, including lymphocyte counts of at least 800 cells/microliter must be provided.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

MAVYRET

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

MAVYRET

EXCLUSION CRITERIA

Moderate or severe hepatic impairment (Child Pugh B or C)

REQUIRED MEDICAL INFORMATION

HCV RNA level within past 6 months

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA

Criteria will be applied consistent with current AASLD/IDSA guidance. Trial of a preferred formulary alternative including Harvoni or Epclusa when these agents are considered acceptable for treatment of the specific genotype per AASLD/IDSA guidance. Patient is not concurrently taking any of the following medications not recommended or contraindicated by the manufacturer: carbamazepine, rifampin, ethinyl estradiol-containing medication, atazanavir, darunavir, lopinavir, ritonavir, efavirenz, atorvastatin, lovastatin, simvastatin, rosuvastatin at doses greater than 10mg, or cyclosporine at doses greater than 100mg per day. Patient must not have prior failure of a DAA (direct-acting antiviral) regimen with NS5A-inhibitor and HCV protease inhibitor.

MAYZENT

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

MAYZENT 0.25 MG TABLET, MAYZENT 0.25MG START-1MG MAINT, MAYZENT 1 MG TABLET, MAYZENT 2 MG TABLET

EXCLUSION CRITERIA

Patients with a CYP2C9*3/ *3 genotype.

REQUIRED MEDICAL INFORMATION

Results of CYP2C9 genotype testing. NEW: Baseline liver function test (AST, ALT, bilirubin), complete blood count and documentation provided showing member has received cardiac evaluation (ECG) and ophthalmologic evaluation prior to starting Mayzent. COC: Documentation that member has demonstrated a response to therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Requested dose is within FDA approved recommendation based on member's CYP2C9 genotype.

MEDICALLY ACCEPTED

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ACUTANE, ACTIMMUNE, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, AMMONIUM LACTATE, AMNESTEEM, AMPHOTERICIN B, ATOVAQUONE, BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE, CLARAVIS, DIACOMIT, ISOTRETINOIN 10 MG CAPSULE, ISOTRETINOIN 20 MG CAPSULE, ISOTRETINOIN 30 MG CAPSULE, ISOTRETINOIN 40 MG CAPSULE, LIDOCAINE 5% PATCH, NEXPLANON, PARAGARD T 380-A, POMALYST, QUININE SULFATE, TETRABENAZINE, XGEVA, ZENATANE

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

MEGESTROL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

MEGESTROL 20 MG TABLET, MEGESTROL 40 MG TABLET, MEGESTROL ACETATE 400MG/10ML ORAL SUSPENSION

EXCLUSION CRITERIA

Weight gain conditions excluded from Part D coverage

REQUIRED MEDICAL INFORMATION

Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Maximum recommended daily dose.

MEPERIDINE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

MEPERIDINE 100 MG/ML VIAL, MEPERIDINE 25 MG/ML VIAL, MEPERIDINE 50 MG/5 ML SOLUTION, MEPERIDINE 50 MG/ML VIAL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with SCr, BUN drawn within the past 30 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Medical justification as to why two formulary alternatives such as hydromorphone, fentanyl, oxycodone or methadone cannot be used in patients with decreased renal function or over age 65.

METHADONE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

METHADONE 10 MG/5 ML SOLUTION, METHADONE 5 MG/5 ML SOLUTION, METHADONE HCL 10 MG TABLET, METHADONE HCL 5 MG TABLET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying why at least two long-acting formulary alternatives (Fentanyl patch, Kadian, Morphine ER, Oxycodone ER, or Oxymorphone ER) cannot be used. If the patient is currently receiving treatment with a long-acting opioid medication, a prescriber statement is required indicating all other long-acting opioid medications will be discontinued. For doses above 30mg of methadone daily, consultation with a pain management specialist is required.

MIRIBAVIR

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LIVTENCITY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Clinical information provided by chart notes, historical pharmacy claims review or a physician statement documenting member is refractory to prior therapy with ganciclovir, valganciclovir, cidofovir or foscarnet

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Transplant or infectious disease specialist

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

MS STEP 1

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

AVONEX 30 MCG/0.5 ML SYRINGE, AVONEX PREFILLED SYR 30 MCG KT, AVONEX PEN, BETASERON 0.3 MG INJECTION, DALFAMPRIDINE ER, DIMETHYL FUMARATE, FINGOLIMOD, GILENYA 0.25 MG CAPSULE, GLATIRAMER ACETATE, GLATOPA, PLEGRIDY 125 MCG/0.5 ML SYRING, PLEGRIDY 125 MCG/0.5 ML PEN, REBIF, REBIF REBIDOSE, TASCENSO ODT, TERIFLUNOMIDE, VUMERITY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

MYCITE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ABILIFY MYCITE 10 MG, ABILIFY MYCITE 15 MG, ABILIFY MYCITE 2 MG, ABILIFY MYCITE 20 MG, ABILIFY MYCITE 30 MG, ABILIFY MYCITE 5 MG

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

(1) Medical justification specifying that two formulary alternatives (olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient, (2) Evidence by paid pharmacy claims that member is currently prescribed aripiprazole and has no adverse effects to the drug, (3) Documented history of medication non-compliance, and (4) Evidence that patient and provider have access to technology that is sufficient for tracking the usage of Abilify Mycrite.

MYFEMBREE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

MYFEMBREE

EXCLUSION CRITERIA

A diagnosis of osteoporosis defined as a history of fragility fracture or T-score less than or equal to 2.5 standard deviations at any site based upon bone mineral density (BMD) measurement by dual-energy x-ray absorptiometry (DXA)

REQUIRED MEDICAL INFORMATION

BMD measurement within the past 3 months

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

1) For treatment of heavy menstrual bleeding: medical justification that hormonal contraceptives and tranexamic acid have been tried and failed, are contraindicated, or would not be medically appropriate for the patient. 2) The cumulative approval duration is limited to a total 24 months in a patients lifetime.

NARCOLEPSY

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ARMODAFINIL, MODAFINIL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Results of a sleep study supporting the diagnosis. (armodafinil, modafinil): Narcolepsy- positive polysomnography (sleep study) for Narcolepsy and dose does not exceed FDA label maximum. (armodafinil, modafinil): Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS)- patient has positive polysomnography for OSAHS, and hypersomnolence score of at least 10 on the Epworth Sleepiness Scale and dose does not exceed FDA label maximum. (armodafinil, modafinil): Shift Work Sleep Disorder (SWSD)- patient is night shift worker with hours of 11pm-7am, early morning shift worker with starting hours between 4am -7am, or rotating shift worker with night shifts, and dose does not exceed FDA label maximum. (armodafinil, modafinil): Refractory Depression- prescribed or recommended by a psychiatrist OR patient has failed therapy with one prior antidepressant regimen and is experiencing symptoms of fatigue or excessive daytime sedation while on the current antidepressant regimen, and modafinil will be added to current regimen, and dose does not exceed FDA label maximum. (armodafinil, modafinil): Bipolar depression- dose does not exceed FDA label maximum.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

If the patient is receiving concomitant sedatives (ramelteon, zaleplon, zolpidem) or benzodiazepines (alprazolam, chlordiazepoxide, clobazam, clonazepam, diazepam, estazolam, flurazepam, lorazepam, oxazepam, quazepam, temazepam, triazolam), justification as to why both agents are medically

necessary.

NATPARA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NATPARA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs including serum calcium, albumin, and 25-hydroxyvitamin D.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

If 25-hydroxyvitamin D stores are insufficient and the patient is not on replacement therapy, medical justification is required. For maintenance therapy, if the corrected serum calcium is above 9 mg/dL, the dose must be decreased, or medical justification is required.

NAYZILAM

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NAYZILAM

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information provided that the member is on existing antiepileptic therapy and is experiencing acute, intermittent, or frequent seizure activity.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

NEUMEGA

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

PROMACTA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

CBC with differential drawn within the past 30 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

N/A

NEXLETOL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NEXLETOL, NEXLIZET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Lipid panel, ALT, AST drawn within the past 30 days. For diagnosis of clinical atherosclerotic cardiovascular disease, diagnosis confirmed by one of the following: acute coronary syndrome, coronary or other arterial revascularization, history of MI, peripheral arterial disease, angina, stroke, or TIA.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Clinical information provided that the patient is utilizing the maximally tolerated dose of any statin or a prescriber attestation of statin-intolerance, and history of previous failure with ezetimibe.

NIACIN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NIACIN ER

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

AST, ALT, Uric Acid, Fasting Glucose or A1c drawn within the previous 3 months.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Medical justification specifying that two formulary statins (atorvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) or two formulary fibrates (fenofibrate or gemfibrozil) have been tried and failed, are contraindicated, or would not be medically appropriate (e.g. statin intolerance) for the patient.

NORTHERA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DROXIDOPA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

2 weeks

OTHER CRITERIA

N/A

NUCALA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NUCALA

EXCLUSION CRITERIA

Current respiratory disease other than asthma.

REQUIRED MEDICAL INFORMATION

For severe asthma: blood eosinophils of greater than or equal to 150 cells/mcL at initiation of therapy (within 6 weeks of dosing) or blood eosinophils of greater than or equal to 300 cells/mcL within 12 months prior to initiation of therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

NUEDEXTA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NUEDEXTA

EXCLUSION CRITERIA

Not approved if the patient has any of the following: concomitant use with quinine, quinidine, or mefloquine, history of quinidine, quinine or mefloquine-induced thrombocytopenia, hepatitis, or other hypersensitivity reactions, known hypersensitivity to dextromethorphan, use with an MAOI or within 14 days of stopping an MAOI, prolonged qt interval, congenital long qt syndrome, history suggestive of torsades de pointes, or heart failure, complete av block without implanted pacemaker, or patients at high risk of complete at block, concomitant use with drugs that both prolong qt interval and are metabolized by cyp2d6 (e.g. thioridazine, pimozide).

REQUIRED MEDICAL INFORMATION

Diagnosis of PBA and diagnostic test results supporting the dx of PBA such as center of neurology study-lability scale (cns-ls) result.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

Initial: 3 months. Continuation: 1 year

OTHER CRITERIA

For re-authorization, the following are needed: documentation of improvement in response to therapy based on cns-ls score after 90 days of treatment and documentation of ongoing CBC, LFT and cardiac monitoring.

NYMALIZE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

NYMALIZE 60 MG/10ML ORAL SYRINGE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

21 days

OTHER CRITERIA

Clinical information provided that oral nimodipine capsules are not appropriate or otherwise contraindicated.

OCALIVA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

OCALIVA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For new therapy: Diagnosis is confirmed by two of the following: (1) Alkaline phosphatase (ALP) level of at least 1.5x upper limit of normal (ULN), (2) The presence of antimitochondrial antibodies (AMA) at a titer of 1:40 or higher, or (3) Histologic evidence of non-suppurative destructive cholangitis and destruction of interlobular bile ducts.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

(1) Medical justification that Ursodiol has been tried and failed (at a dosage of 13-15mg/kg/day for at least one year), is contraindicated, or would not be medically appropriate for the patient. (2) Ocaliva will be used in combination with ursodiol (unless contraindicated, or not medically appropriate for the patient).

OFEV

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

OFEV

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information provided to support the following: (1A) Confirmation of a diagnosis of IPF by ruling out history of environmental exposure known to cause pulmonary fibrosis or other causes of pulmonary fibrosis, (1B) Histological or radiographic evidence confirming the diagnosis of IPF, (1C) FVC between 50% and 90%, and (1D) Liver function tests, or (2A) a diagnosis of systemic sclerosis-associated interstitial lung disease confirmed by greater than 10% fibrosis on high-resolution computed tomography, (2B) a baseline FVC greater than or equal to 40%, and (2C) a baseline predicted diffusing capacity of the lung for carbon monoxide between 30 and 89%, or (3A) a diagnosis of chronic fibrosing interstitial lung disease confirmed by greater than 10% fibrosis on high-resolution computed tomography, (3B) a baseline FVC greater than or equal to 45%, (3C) a baseline predicted diffusing capacity of the lung for carbon monoxide between, 30 and 79%, and (3D) a progressive phenotype.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Pulmonology

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

OLUMIANT

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

OLUMIANT 1 MG TABLET, OLUMIANT 2 MG TABLET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: For rheumatoid arthritis (RA), previous trial of or contraindication to two of the following preferred agents: Humira, Enbrel, Xeljanz, Rinvoq.

OPHTHALMIC QUINOLONE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

BESIVANCE, CILOXAN 0.3% OINTMENT

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 month

OTHER CRITERIA

Medical justification specifying that two formulary alternatives without prior authorization restriction (ciprofloxacin, gatifloxacin, levofloxacin, or ofloxacin ophthalmic solution) have been tried and failed, are contraindicated, or are not medically appropriate for the patient, OR an ophthalmologist or optometrist has prescribed the medication or provided a consult to recommend the medication.

ORAL ALLERGENS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

GRASTEK, ODACTRA, ORALAIR 300 MG SUBLINGUAL TABLET

EXCLUSION CRITERIA

Uncontrolled Asthma, Eosinophilic esophagitis

REQUIRED MEDICAL INFORMATION

New: Clinical information documenting a diagnosis confirmed by one of the following: positive skin prick test OR In vitro testing showing positive pollen-specific IgE antibodies. COC: Documentation of response to therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Allergy/Immunology

COVERAGE DURATION

1 year

OTHER CRITERIA

(1) Medical justification specifying that two of the following classes have been tried and failed, are contraindicated, or would not be medically appropriate for the patient: oral antihistamines (cetirizine, loratadine, desloratadine, or fexofenadine), intranasal antihistamines (azelastine), intranasal corticosteroids (fluticasone, flunisolide or triamcinolone) or leukotriene inhibitor (montelukast). (2) Clinical information indicating the member has an epinephrine auto-injector/syringe prescription.

ORAL SUSPENSION

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CAROSPIR 5 MG/ML ORAL SUSPENSION, EPRONTIA, SEVELAMER 2.4 GM POWDER PACKET, VIGABATRIN 500 MG POWDER PACKET, ZONISADE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying why oral tablet or capsule formulation cannot be used.

ORAL VANCO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VANCOMYCIN HCL 125 MG CAPSULE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

2 weeks

OTHER CRITERIA

N/A

ORENCIA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ORENCIA 125 MG/ML SYRINGE, ORENCIA 50 MG/0.4 ML SYRINGE, ORENCIA 87.5 MG/0.7 ML SYRINGE, ORENCIA CLICKJECT

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Rheumatoid arthritis (RA): previous trial of or contraindication to any two of the following preferred agents: Humira, Enbrel, Xeljanz, Rinvoq. Polyarticular juvenile idiopathic arthritis (PJIA): previous trial or contraindication to any TWO of the following: Humira, Enbrel or Xeljanz. Psoriatic arthritis (PSA): previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Xeljanz, Rinvoq, Skyrizi.

ORIAHNN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ORIAHNN

EXCLUSION CRITERIA

A diagnosis of osteoporosis defined as a history of fragility fracture or T-score less than or equal to 2.5 standard deviations at any site based upon bone mineral density (BMD) measurement by dual-energy x-ray absorptiometry (DXA)

REQUIRED MEDICAL INFORMATION

BMD measurement within the past 3 months

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

1) Medical justification that hormonal contraceptives and tranexamic acid have been tried and failed, are contraindicated, or would not be medically appropriate for the patient. 2) The cumulative approval duration is limited to a total 24 months in a patients lifetime.

ORLADEYO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ORLADEYO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: (1) Documentation of HAE confirmed by lab work (HAE I: low C4 level AND low C1-INH antigenic level, HAE II: low C4 level AND normal or elevated C1-INH antigenic level AND low C1-INH function level, HAE III: low C4 level AND normal C1-INH antigenic level AND normal C1-INH function level AND documentation of a family history of HA or FXII mutation).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

Member is not receiving medications that can worsen the severity or frequency of angioedema episodes (estrogen-containing products, angiotensin-converting enzyme [ACE] inhibitors, others). Medical justification specifying that the member has a contraindication or intolerance to Haegarda. COC: (1) documentation or record of disease state improvement (such as decrease in the number, severity, and/or duration of the acute HAE attacks) within the last 6 months and (2) member is receiving only one agent for HAE attacks.

OTEZLA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

OTEZLA 28 DAY STARTER PACK, OTEZLA 30 MG TABLET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Psoriasis: prescribed by or in consultation with a dermatologist. Behcets disease: prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Psoriatic arthritis (PSA) previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Xeljanz, Rinvoq, Skyrizi. Plaque psoriasis (PSO): previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Skyrizi. 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, etc.)

OXBRYTA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

OXBRYTA 300 MG TABLET, OXBRYTA 500 MG TABLET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

(1) Hemoglobin level drawn in the last 30 days with result between 5.5 and 10.5 mg/dL and (2) clinical information indicating a history of least 1 vaso-occlusive crisis within the previous 12 months.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Information that member is either currently stable on hydroxyurea or that hydroxyurea has been tried and failed, is contraindicated, or would not be medically appropriate.

OXYBATE SALTS

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

SODIUM OXYBATE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For Narcolepsy: results of a sleep study supporting the diagnosis and dose does not exceed FDA label maximum.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

If the patient is receiving concomitant sedatives (ramelteon, zaleplon, zolpidem) or benzodiazepines (alprazolam, chlordiazepoxide, clobazam, clonazepam, diazepam, estazolam, flurazepam, lorazepam, oxazepam, quazepam, temazepam, triazolam), justification as to why both agents are medically necessary.

OXYBATE SALTS

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

XYREM, XYWAV

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For Narcolepsy: results of a sleep study supporting the diagnosis and dose does not exceed FDA label maximum.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

If the patient is receiving concomitant sedatives (ramelteon, zaleplon, zolpidem) or benzodiazepines (alprazolam, chlordiazepoxide, clobazam, clonazepam, diazepam, estazolam, flurazepam, lorazepam, oxazepam, quazepam, temazepam, triazolam), justification as to why both agents are medically necessary.

PACRITINIB

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VONJO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New:Labs showing platelet counts less than 50,000. COC: Clinical documentation of continued benefit

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

Initial:6 months.COC:1 year

OTHER CRITERIA

N/A

PAH

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ADEMPAS, AMBRISENTAN, BOSENTAN, OPSUMIT, ORENITRAM ER, ORENITRAM MONTH 1 TITRATION KT, ORENITRAM MONTH 2 TITRATION KT, ORENITRAM MONTH 3 TITRATION KT, SILDENAFIL, SILDENAFIL 10 MG/ML ORAL SUSP, SILDENAFIL 20 MG TABLET, TADALAFIL 20MG TABLET (ADCIRCA GENERIC), TADLIQ, TRACLEER 32 MG TABLET FOR SUSP, VENTAVIS

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

FDA approved functional class (WHO Group or NYHA class)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For new requests: The diagnosis of PAH (pulmonary arterial hypertension) is confirmed by right heart catheterization, the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition, and the medication used for treatment is consistent with its FDA approved functional class. For continuation of therapy: Documentation that the medication has been effective (i.e. member is stable on current dose and/or no evidence of disease progression). For initiation of combination therapy with 3 agents: Patient is refractory or poorly responsive to 2-drug combination therapy and the 3 agents must have different mechanisms of action.

PALBOCICLIB

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

IBRANCE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

The patient has not experienced disease progression following prior CDK inhibitor therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PALYNZIQ

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PALYNZIQ

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Baseline labs showing blood phenylalanine level is greater than 600 micromole/L within the past 30 days. Continuation: documentation of reduced phenylalanine levels from baseline.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification that Kuvan has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

PANCREATIC ENZYME

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CREON, PANCREAZE, PERTZYE, VIOKACE, ZENPEP

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Test result confirming diagnosis such as one of the following: (1) Fecal elastase-1 less than 200mcg elastase/g fecal material. (2) Secretin tradition test result shows peak bicarbonate concentration less than 80mEq/L, (3) Secretin endoscopic test result shows peak bicarbonate concentration less than 80 mEq/L for the 1-hour method or less than 75 mEq/L for the shortened test, or (4) Fecal fat excretion greater than 7% of fat intake in 72-hour stool test.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PAR-1 ANTAGONIST

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ZONTIVITY

EXCLUSION CRITERIA

A history of stroke, transient ischemic attack (TIA), or intracranial hemorrhage (ICH), or active pathological bleeding.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Cardiology

COVERAGE DURATION

1 year

OTHER CRITERIA

Must be used in combination with aspirin and/or clopidogrel

PARP INHIBITOR

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

AKEEGA, LYNPARZA, RUBRACA, ZEJULA 100 MG CAPSULE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

1 year

OTHER CRITERIA

The member has a deleterious or suspected deleterious BRCA mutation (as detected by an FDA approved test), or clinical information provided to support use consistent with FDA-approved labeling.

PART D

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ALOSETRON HCL, ARALAST NP 1,000 MG VIAL, BETAINE ANHYDROUS, BRIVIACT 10 MG TABLET, BRIVIACT 10 MG/ML ORAL SOLN, BRIVIACT 100 MG TABLET, BRIVIACT 25 MG TABLET, BRIVIACT 50 MG TABLET, BRIVIACT 75 MG TABLET, CALCIPOTRIENE 0.005% CREAM, CALCIPOTRIENE 0.005% OINTMENT, CALCIPOTRIENE 0.005% SOLUTION, CAYSTON, CINRYZE, CLOBAZAM, CROTAN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 25 MG TABLET, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG TABLET, DESVENLAFAXINE ER, DIAZOXIDE, DICHLORPHENAMIDE, DIHYDROERGOTAMINE 4 MG/ML SPRY, DRONABINOL, ELMIRON, EMSAM, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, ERGOLOID MESYLATES, ESBRIET 267 MG CAPSULE, FINTEPLA, FLUCYTOSINE, GARDASIL 9, GLASSIA, HEPLISAV-B 20 MCG/0.5 ML SYRNG, ICATIBANT, KEVEYIS, OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL, OCTREOTIDE ACET 500 MCG/ML AMP, OCTREOTIDE ACET 500 MCG/ML VL, ORKAMBI, PHENOXYBENZAMINE HCL, PIRFENIDONE, PREHEVBRIO, PROLASTIN C 1,000 MG VIAL, PULMOZYME, PYRIMETHAMINE, RECOMBIVAX HB, RUFINAMIDE, SAJAZIR, SYMPAZAN, SYNDROS, UPTRAVI 1,000 MCG TABLET, UPTRAVI 1,200 MCG TABLET, UPTRAVI 1,400 MCG TABLET, UPTRAVI 1,600 MCG TABLET, UPTRAVI 200 MCG TABLET, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG TABLET, VALGANCICLOVIR 450 MG TABLET, ZEMAIRA

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PART D 3 MONTH

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CLINIMIX 4.25%-10% SOLUTION, CLINIMIX 4.25%-5% SOLUTION, CLINIMIX 5%-15% SOLUTION, CLINIMIX 5%-20% SOLUTION, CLINIMIX E 2.75%-5% SOLUTION, CLINIMIX E 4.25%-10% SOLUTION, CLINIMIX E 4.25%-5% SOLUTION, CLINIMIX E 5%-15% SOLUTION, CLINIMIX E 5%-20% SOLUTION, CLINISOL, CYSTARAN, INTRALIPID, NUTRILIPID, PARICALCITOL 1 MCG CAPSULE, PARICALCITOL 2 MCG CAPSULE, PARICALCITOL 4 MCG CAPSULE, PLENAMINE, PREMASOL 10% IV SOLUTION, PROSOL, REGRANEX, SIRTURO, TOBI PODHALER, TRAVASOL, TRIENTINE HCL 250 MG CAPSULE, TROPHAMINE 10% IV SOLUTION

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

PART D VS PART B

MEDICATION(S)

AZASAN, AZATHIOPRINE, CELLCEPT 200 MG/ML ORAL SUSP, CELLCEPT 250 MG CAPSULE, CELLCEPT 500 MG TABLET, CINACALCET HCL, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE MODIFIED, EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, EVEROLIMUS 1 MG TABLET, GENGRAF, KYLEENA, LILETTA, MIRENA, MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, MYCOPHENOLIC ACID, MYFORTIC, NEORAL, PROGRAF 0.2 MG GRANULE PACKET, PROGRAF 0.5 MG CAPSULE, PROGRAF 1 MG CAPSULE, PROGRAF 1 MG GRANULE PACKET, PROGRAF 5 MG CAPSULE, RAPAMUNE, SANDIMMUNE 100 MG CAPSULE, SANDIMMUNE 100 MG/ML SOLN, SANDIMMUNE 25 MG CAPSULE, SIROLIMUS, SKYLA, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 0.5 MG CAPSULE (IR), TACROLIMUS 1 MG CAPSULE, TACROLIMUS 1 MG CAPSULE (IR), TACROLIMUS 5 MG CAPSULE, TACROLIMUS 5 MG CAPSULE (IR), ZORTRESS

DETAILS

This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

PCSK9

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PRALUENT PEN, REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

EXCLUSION CRITERIA

Concurrent use with another PCSK9 agent (Praluent, Repatha) or a lipotropic agent (Juxtapid, Kynamro).

REQUIRED MEDICAL INFORMATION

Lipid panel drawn within the past 30 days. For continuation of therapy, baseline lipid panel. For Heterozygous Familial Hypercholesterolemia (HeFH) or Homozygous Familial Hypercholesterolemia (HoFH), confirmation of the diagnosis by LDLR DNA Sequence Analysis, LDLR Deletion/Duplication Analysis (only if the Sequence Analysis is negative), APOB and PCSK9 testing (if both of the above tests are negative but a strong clinical picture exists), or diagnosis by clinical criteria (such as Simon Broome or the Dutch Lipid Network criteria for HeFH, or history of untreated LDL-C greater than 500 mg/dL together with Xanthoma before 10 years of age), or evidence of HeFH in both parents. For Primary Hyperlipidemia, documented LDL-C must be 70mg/dL or higher while on the maximally tolerated statin therapy (unless contraindicated) or provide a medical justification as to why statin therapy would not be medically appropriate (e.g. statin intolerance).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For all treatable medical conditions, must currently take high-intensity statin. If there has been a previous trial/failure of either atorvastatin or rosuvastatin, then must currently take maximally tolerated dose of any statin or provide a prescriber attestation of statin-intolerance. For cardiovascular risk reduction, LDL-C must be 70mg/dL or higher while on maximal treatment, and at least one of the

following is required: acute coronary syndrome, coronary or other arterial revascularization, history of MI, peripheral arterial disease presumed to be of atherosclerotic origin, stable or unstable angina, stroke, or TIA. For continuation of therapy, criteria have been satisfied AND there is confirmation of LDL reduction.

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NEUPRO, ONGENTYS, TOLCAPONE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying that one formulary alternative (bromocriptine, pramipexole, or ropinirole, entacapone, or selegiline) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient. When indicated as adjunct therapy, concomitant use with formulary alternatives will be approved.

PEGASYS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PEGASYS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

HCV RNA level within past 6 months.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Hep B: 48 weeks. Hep C: Criteria will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA

Criteria will be applied consistent with current AASLD-IDSA guidance. For requests for use of peginterferon as part of a combination regimen with other Hepatitis C virus (HCV) antiviral drugs: trial with preferred formulary alternative ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, or Mavyret where the regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. No approval for requests where provider attests that patient has life expectancy less than 12 months due to non-liver related comorbid conditions (per AASLD/IDSA treatment guideline recommendation).

PERSERIS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PERSERIS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Psychiatry

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical documentation establishing tolerability with oral risperidone before starting Perseris.

PONVORY

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PONVORY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Trial of or contraindication to ONE sphingoside-1-phosphate receptor modulator and ONE other agent indicated for treatment of multiple sclerosis.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PREVYMIS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PREVYMIS 240 MG TABLET, PREVYMIS 480 MG TABLET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Diagnosis is allogeneic hematopoietic stem cell transplant (HSCT), use is for prophylaxis of CMV infection and disease, patient is CMV-seropositive [R+], therapy will be initiated between day 0 and day 28 post-transplantation. For continuation of treatment beyond 100 days post-transplant, medical justification is required.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

N/A

PROGESTINS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CRINONE

EXCLUSION CRITERIA

Infertility treatment.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Maximum recommended daily dose.

PROLIA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PROLIA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For NEW treatment of osteoporosis: (1) BMD T-Score of less than or equal to -2.5 AND intolerance to ONE oral bisphosphonate OR IV zoledronic acid OR (2) history of fracture plus one or more risk factors for osteoporotic fracture. For NEW treatment of bone loss: has one or more risk factors for osteoporotic fracture and evidence of concurrent androgen deprivation therapy for prostate cancer OR adjuvant aromatase inhibitor therapy for breast cancer. Risk factors for fracture may include but are not limited to: (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months, low body weight, smoking, alcohol intake of 3 or more drinks/day, rheumatoid arthritis, hypogonadism or premature ovarian failure, chronic liver disease or inflammatory bowel disease).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PTH ANALOG

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

FORTEO, TERIPARATIDE 620 MCG/2.48 ML, TYMLOS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

BMD (bone mineral density) measurements or fracture documentation.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Patient has one of the following: (A) Has been refractory to a trial of an oral bisphosphonate therapy OR (B) Intolerance or contraindications to oral bisphosphonate as defined by having at least one of the following: 1. Hypersensitivity to TWO oral bisphosphonates (one of which must be alendronate) 2. Inability to sit or stand upright for at least 30 minutes, 3. Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.). 4. Uncorrected hypocalcemia. 5. Severe renal insufficiency as defined by creatinine clearance less than 35 mL/min for alendronate agents or creatinine clearance less than 30 mL/min for risedronate and ibandronate.

PYRUKYND

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

PYRUKYND, PYRUKYND 20 MG TABLET, PYRUKYND 50 MG TABLET, PYRUKYND 5MG TABLET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: (1) Confirmation of pyruvate kinase deficiency, and (2A) Labs within past 30 days showing hemoglobin level 10 g/dL or less OR (2B) evidence of 6 or more blood transfusions within the previous 52 weeks. COC: Labs within past 30 days showing hemoglobin level increased from the baseline or evidence that the number of blood transfusions has decreased from baseline.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology

COVERAGE DURATION

New: 24 weeks, COC: 1 year

OTHER CRITERIA

N/A

QBREXZA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

QBREXZA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Hyperhidrosis Disease Severity Scale (HDSS) of 3 or 4. COC: Hyperhidrosis Disease Severity Scale (HDSS) of improved by 2 or more points.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

RADICAVA ORS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

RADICAVA ORS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology, Pulmonology

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying that riluzole tablet AND Radicava injectable has been tried and failed, are contraindicated, or would not be medically appropriate for the patient. Part B Prerequisite Required

RANEXA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ASPRUZYO SPRINKLE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying why one formulary alternative cannot be used (acebutolol, atenolol, betaxolol, bisoprolol, carvedilol, labetalol, metoprolol, nadolol, pindolol, propranolol, timolol, diltiazem, verapamil, amlodipine, felodipine, isosorbide dinitrate, isosorbide mononitrate, transdermal nitroglycerin, or translingual nitroglycerin).

RECORLEV

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

RECORLEV

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: (1) Clinical information indicating pituitary surgery is not an option or has not been curative and (2) baseline 24-hour urinary free cortisol (UFC) level. COC: Labs within past 30 days documenting 24-hour urinary free cortisol (UFC) level has decreased from baseline.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Endocrinology

COVERAGE DURATION

6 months

OTHER CRITERIA

Medical justification specifying that oral ketoconazole has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

RELISTOR

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

RELISTOR

EXCLUSION CRITERIA

Individual has a known or suspected mechanical gastrointestinal obstruction.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Individual must have a previous trial of or insufficient response to polyethylene glycol (generic MiraLax) AND a trial and inadequate response or intolerance to a preferred agent (Movantik/Amitiza) OR the preferred agent (Movantik/Amitiza) is not acceptable due to concomitant clinical situations, warnings or contraindications, such as but not limited to the following: (1) individual is taking a diphenylheptane opioid (e.g., methadone), where effectiveness has not been established in the treatment of OIC (Amitiza) OR (2) individual has disruption to the blood-brain barrier and may be at increased risk for opioid withdrawal and/or reduced analgesia (Movantik) OR (3) individual is taking strong CYP3A4 inhibitors and may be at increased risk for opioid withdrawal and/or reduced analgesia (Movantik).

RELYVRIO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

RELYVRIO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

1 year

OTHER CRITERIA

Evidence that patient is currently on riluzole or has tried riluzole in the past

REVCovi

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

REVCovi

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

REZUROCK

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

REZUROCK

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Medical justification specifying that at least 2 prior lines of systemic therapy have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

RIBAVIRIN

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

RIBAVIRIN 200 MG CAPSULE, RIBAVIRIN 200 MG TABLET

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

HCV RNA level (viral load), Hepatitis C Virus (HCV) genotype drawn within the past 6 months.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Hep C: Per current AASLD/IDSA guidance. Hep B: 16 wks. Other: 1 yr.

OTHER CRITERIA

Criteria will be applied consistent with current AASLD/IDSA guidance

RIBOCICLIB

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

KISQALI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

The member: (1) Has no prior endocrine therapy and is being treated in combination with aromatase therapy (e.g. anastrozole, letrozole, exemestane), or (2) Is a man or postmenopausal woman and being treated in combination with fulvestrant (Faslodex).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

1 year

OTHER CRITERIA

Requires a trial of or contraindication to Verzenio or Ibrance where indications align.

RIBOCICLIB-LETROZOLE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

KISQALI FEMARA CO-PACK

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

1 year

OTHER CRITERIA

Member has not had prior endocrine therapy.

RINVOQ

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

RINVOQ

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Rheumatoid arthritis (RA) and Psoriatic arthritis (PSA): The member has a history of failure, contraindication, or reason(s) for intolerance to TNF blockers (e.g. Humira or Enbrel). Atopic Dermatitis (AD): The member has a history of failure, contraindication, or reason(s) for intolerance to topical corticosteroid or topical immunomodulating agent. Ulcerative colitis (UC): The member has a history of failure, contraindication, or reason(s) for intolerance to TNF blockers (e.g. Humira or Enbrel). Ankylosing Spondylitis (AS): The member has a history of failure, contraindication, or reason(s) for intolerance to TNF blockers (e.g. Humira or Enbrel).

RYDAPT

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

RYDAPT

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

1 year

OTHER CRITERIA

For Advanced Systemic Mastocytosis with KIT D816V mutation status negative/unknown, medical justification is required why Gleevec cannot be used.

SAVELLA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SAVELLA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For Fibromyalgia, individual had a trial of and insufficient response or intolerance to TWO of the following: (1) Cymbalta (duloxetine HCl) (2) Gabapentin (3) Tricyclic antidepressants (such as, amitriptyline, clomipramine, desipramine, nortriptyline), (4) Cyclobenzaprine OR (5) Fluoxetine.

SIGNIFOR

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SIGNIFOR

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Fasting plasma glucose, hemoglobin A1C, liver function tests, ECG, and gallbladder ultrasound.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Endocrinology

COVERAGE DURATION

1 year

OTHER CRITERIA

For patients with Cushing's disease not due to pituitary tumor, medical justification is required.

SILIQ

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SILIQ

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Plaque psoriasis: previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Skyrizi. Patient has been counseled on and expresses understanding of the risk of suicidal ideation and behavior. Renewal: patient has not developed or reported worsening depressive symptoms or suicidal ideation and behaviors while on treatment with Siliq. The quantity will be limited to 3 syringes for the first 28 days of therapy. For maintenance therapy, the quantity will be limited to 2 syringes per 28 days. Medical justification is required to exceed the quantity limits.

SIMPONI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SIMPONI, SIMPONI ARIA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Rheumatoid arthritis (RA): previous trial of or contraindication to any two of the following preferred agents: Humira, Enbrel, Xeljanz, or Rinvoq. Psoriatic arthritis (PSA): previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Xeljanz, Rinvoq, or Skyrizi. Ankylosing spondylitis (AS): previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Enbrel, Rinvoq, or Xeljanz. Ulcerative colitis (UC): previous trial of or contraindication to two of the following: Humira, Rinvoq, Stelara, or Xeljanz.

SKYRIZI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SKYRIZI, SKYRIZI ON-BODY, SKYRIZI PEN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Moderate to severe psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Plaque psoriasis (PSO): previous 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. The quantity will be limited to 4 syringes for the first 28 days of therapy. For maintenance therapy, the quantity will be limited to 2 syringes per 84 days. Medical justification is required to exceed the quantity limits.

SNRI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

FETZIMA, TRINTELLIX, VIIBRYD 10-20 MG STARTER PACK, VILAZODONE HCL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Documentation or record of the symptoms and duration of the episode. For treatment of depression, the depression rating scale and score are required.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying that two of the formulary alternatives (citalopram, desvenlafaxine, escitalopram, fluoxetine, paroxetine, sertraline or venlafaxine) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

SOLIQUA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SOLIQUA 100-33

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Patients must currently be inadequately controlled on basal insulin (i.e. Basaglar, Lantus, Levemir, Toujeo, or Tresiba) less than 60 units daily. A prescriber statement is required to confirm that basal insulin will be discontinued when treatment with Soliqua begins. Patients must also have tried and failed a glucagon-like peptide (i.e. Adlyxin, Byetta, Bydureon, Tanzeum, Trulicity, or Victoza) within the previous 180 days.

SOLOSEC

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SOLOSEC

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 day

OTHER CRITERIA

Medical justification specifying that tinidazole, clindamycin or metronidazole have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

SORIATANE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ACITRETIN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

N/A

SOTYKTU

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SOTYKTU

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Psoriasis: prescribed by or in consultation with a dermatologist.

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Plaque psoriasis (PSO): previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Skyrizi, Tremfya.

SOVALDI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SOVALDI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA

Criteria will be applied consistent with current AASLD/IDSA guidance. Trial with preferred formulary alternative ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, or Mavyret where that regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. For patients on Sovaldi plus Daklinza regimens there will be no approvals for concurrent use of any of these (contraindicated or not recommended by the manufacturer) medications: amiodarone, carbamazepine, phenytoin, or rifampin. Requests for Sovaldi in combination with Daklinza will require that the patient also meets all criteria for Daklinza.

STELARA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

STELARA 45 MG/0.5 ML SYRINGE, STELARA 45 MG/0.5 ML VIAL, STELARA 90 MG/ML SYRINGE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Moderate to severe psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Plaque psoriasis: prescribed by or in consultation with a dermatologist. Crohns disease/Ulcerative Colitis: prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Psoriatic arthritis: previous trial of or contraindication to at least one DMARD (disease-modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. Plaque psoriasis: previous trial of or contraindication at least one conventional therapy such as PUVA (phototherapy ultraviolet light A), UVB (ultraviolet light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. Crohns disease: previous trial of or contraindication to at least one conventional therapy such as corticosteroids (i.e. budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine.

SYMDEKO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SYMDEKO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Baseline FEV1 and recent laboratory report within the past 90 days showing ALT, AST, and bilirubin levels are within normal range. Confirmed genetic testing for homozygous F508del mutation of the CFTR gene or a CFTR (cystic fibrosis transmembrane conductance regulator) gene mutation that is responsive to the Symdeko per package labeling. COC: Confirmation that member has improvement of symptoms (i.e. improved FEV1, weight gain, or decreased exacerbation). Recent laboratory report (within last 90 days) for ALT, AST, and bilirubin are within normal range.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

SYMLIN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SYMLINPEN 120, SYMLINPEN 60

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification for patients receiving concomitant metoclopramide, Precose or Glyset, patients with an A1c over 9%, patients not receiving concomitant insulin, patients with a diagnosis of gastroparesis.

TABRECTA

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

TABRECTA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

1 year

OTHER CRITERIA

Documentation of tumor mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an FDA approved test

TAKHZYRO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TAKHZYRO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

(1) Documentation of HAE confirmed by lab work (HAE I: low C4 level AND low C1-INH antigenic level, HAE II: low C4 level AND normal or elevated C1-INH antigenic level AND low C1-INH function level, HAE III: low C4 level AND normal C1-INH antigenic level AND normal C1-INH function level AND documentation of a family history of HA or FXII mutation).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Member is not receiving medications that can worsen the severity or frequency of angioedema episodes (estrogen-containing products, angiotensin-converting enzyme [ACE] inhibitors, others). Medical justification specifying that the member has a contraindication or intolerance to Haegarda. COC: (1) documentation or record of disease state improvement (such as decrease in the number, severity, and/or duration of the acute HAE attacks) within the last 6 months, and (2) member is receiving only one agent for HAE attacks.

TALTZ

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TALTZ 80 MG/ML AUTOINJECTOR, TALTZ 80 MG/ML SYRINGE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Moderate to severe psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Plaque psoriasis (PSO): previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Stelara, Enbrel, Skyrizi. Psoriatic arthritis (PSA): previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Stelara, Enbrel, Xeljanz, Rinvoq, Skyrizi. Ankylosing spondylitis (AS): previous trial of or contraindication to any two of the following preferred agents: Enbrel, Humira, Cosentyx, Rinvoq, or Xeljanz. Non-Radiographic Axial Spondyloarthritis (NR-SpA): previous trial of or contraindication to Cosentyx. Medical justification is required to exceed the quantity limits. The member has a history of failure, contraindication, or reason(s) for intolerance to The quantity will be limited to 7 pens or syringes for the first 84 days of therapy. For maintenance therapy, the quantity will be limited to 1 pen or syringe per 28 days.

TARPEYO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TARPEYO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

(1) Diagnosis of primary IgAN confirmed by biopsy, (2) Member is currently receiving therapy with an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB), (3) Confirmation of proteinuria as evidenced by equal to or greater than 1 g/day or a UPCR equal to equal to or greater than 0.8 g/g, (4) Patient has an eGFR of 35 L/min or greater, (5) History of failure, contraindication, or reason(s) for intolerance to an alternative oral corticosteroid (methylprednisolone, prednisolone, prednisone).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Nephrology or Immunology

COVERAGE DURATION

10 months

OTHER CRITERIA

N/A

TAVALISSE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

TAVALISSE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Platelet count less than 30,000mm³. COC: ALT, AST, and bilirubin (drawn within the last 90 days) less than 3x the upper limit of normal. Documentation of either (1) lab work indicating platelet count greater than 30,000mm³ (drawn within last 90 days), or (2) medical document showing that the platelet count increased compared to baseline demonstrating efficacy (although member may need an increase in dose).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology, Oncology

COVERAGE DURATION

Initial: 3 months. Renewal: 6 months.

OTHER CRITERIA

New: Medical justification specifying that a formulary alternative (corticosteroid [e.g. prednisone, dexamethasone], Promacta, or rituximab (Rituxan)) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient, or that the patient has had a splenectomy.

TAVNEOS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TAVNEOS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information documenting (1) LFTs within past 60 days (2) history of trial and failure (disease relapse or disease remission failure) or a contraindication to treatment with rituximab OR cyclophosphamide, AND glucocorticoids (methylprednisolone or prednisone).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Documentation of concomitant use with a standard immunosuppressive therapy (rituximab OR cyclophosphamide).

Part B Prerequisite Required

TEDUGLUTIDE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

GATTEX 5 MG INJECTION, ZORBTIVE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Approval for continued therapy with Gattex or Zorbtive requires a decrease of parenteral nutritional volume. Quantity limited to #1 vial per day.

TEGSEDI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TEGSEDI

EXCLUSION CRITERIA

Platelet count less than $100 \times 10^9/L$ or UPCR of 1000 mg/g or higher or previous hypersensitivity reaction with use of Tegsed

REQUIRED MEDICAL INFORMATION

Labs for platelet count, serum creatinine, eGFR, AST, ALT, urine protein to creatinine ratio (UPCR), total bilirubin and urinalysis within the past 2 weeks.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

TETRACYCLINE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TETRACYCLINE HCL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Medical justification specifying that one formulary antibacterial including but not limited the following classes (beta lactams, macrolides, fluoroquinolones, aminoglycosides, nitroimidazoles, lincosamides, tetracyclines or sulfonamides) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

THALOMID

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

THALOMID

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

TIOPRONIN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

THIOLA EC, TIOPRONIN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: One of the following: (1) stone analysis positive for cystine, (2) urinalysis positive for pathognomonic hexagonal cystine crystals, (3) family history of cystinuria with a positive cyanide-nitroprusside screen, or (4) 24-hour urine collection with urinary cystine greater than 500. COC: Documentation of positive clinical response to therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

N/A

TOPICAL ANTIHERPETIC

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ACYCLOVIR 5% CREAM, ACYCLOVIR 5% OINTMENT, PENCICLOVIR

EXCLUSION CRITERIA

Herpes zoster.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 month

OTHER CRITERIA

Dose does not exceed FDA label maximum.

TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

FENTANYL CIT OTFC 1,200 MCG, FENTANYL CIT OTFC 1,600 MCG, FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 600 MCG, FENTANYL CITRATE OTFC 800 MCG

EXCLUSION CRITERIA

Any of the following: 1. Management of acute or post-operative pain. 2. Opioid non-tolerant patients. 3. Pain not associated with cancer. 4. Opioid naive.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Concurrent chemotherapy or documentation or record of a diagnosis of cancer is required. Patients must be opioid tolerant, as demonstrated by one week or longer of around-the-clock therapy with a total daily dose of 60 mg of oral morphine (or equivalent dose of another opioid).

TREMFYA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TREMFYA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Moderate to severe psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Initial: Plaque psoriasis: previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel, Skyrizi. Psoriatic arthritis: Does not require trial of any previous therapy.

TRIKAFTA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TRIKAFTA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: (1) Baseline FEV1, weight/ BMI, and (2) Documentation confirming at least one F508del mutation in the CFTR or a CTFR gene responsive based on in vitro data. COC: (1) Information provided that member has had an improved clinical response as indicated by improvement in FEV1, reduced number of pulmonary exacerbations, or improvement in body mass index (BMI).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

Must have a history of failure, contraindication, or reason(s) for intolerance to Orkambi or Symdeko.

TYRVAYA

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

TYRVAYA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Documentation is provided indicating an abnormal result or response to one or more of the following dry eye disease diagnostic/assessment methods (AAO, 2013): (a) Tear break-up time (less than 10 seconds) OR (b) Ocular surface dye staining using fluorescein, rose bengal, or lissamine green dyes OR (c) Schirmer test (aqueous tear production of less than or equal to 10 mm of strip wetting in 5 minutes) OR (d) Fluorescein clearance test/tear function index OR (e) Tear osmolarity (indicating tear film instability) OR (f) Tear lactoferrin concentrations in the lacrimal gland (decreased).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification that cyclosporine and Xiidra eye drops have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

TYVASO DPI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TYVASO DPI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New requests for group 1 PAH: Confirmation of PAH based on right heart catheterization with results showing (1) mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg and (2) pulmonary vascular resistance (PVR) of 3 Wood units or more and (3) pulmonary capillary wedge pressure (PCWP) of 15 mmHg or less AND (1) a baseline 6-minute walk distance (6MWD) test result AND (2) Clinical information documenting patient has World Health Organization (WHO) or New York Heart Association (NYHA) Functional Class III to IV symptoms. Renewal for group 1 PAH: Documentation of either (1) improvement of baseline 6MWD or (2) patient is stable from baseline 6MWD and the WHO/NYHA functional class has improved or remained stable. New requests for group 3 PH: Confirmation of PAH based on right heart catheterization with results showing (1) mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg and (2) pulmonary vascular resistance (PVR) of 3 Wood units or more and (3) pulmonary capillary wedge pressure (PCWP) of 15 mmHg or less and (4) a baseline 6-minute walk distance (6MWD) test result. Renewal for group 3 PH: Documentation of improvement or stable from baseline 6MWD.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Cardiologist or pulmonologist

COVERAGE DURATION

1 year

OTHER CRITERIA

For group 1 PAH only: (1) Tried and Failed TWO of the following ORAL agents from different drug classes: endothelin receptor antagonists (ambrisentan, bosentan or Opsumit), phosphodiesterase 5

inhibitors (sildenafil or tadalafil), oral guanylate cyclase stimulator (Adempas) OR (2) Functional Class III symptoms and documented rapid progression or poor prognosis OR (3) Functional Class IV symptoms and has tried and failed or has contraindication to IV/SQ epoprostenol or treprostinil.

UBRELVY

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

UBRELVY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Medical justification specifying that TWO formulary anti-migraine drugs from different classes have been tried and failed are contraindicated, or would not be medically appropriate. Classes include: (1) Analgesics- acetaminophen, aspirin, naproxen, ibuprofen, diclofenac, (2) Triptans- sumatriptan, rizatriptan/rizatriptan ODT, naratriptan, or zolmitriptan/zolmitriptan ODT, and (3) Antiemetics- prochlorperazine. COC: Documentation of positive clinical response to therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (i.e., Nurtec ODT)

UCERIS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

BUDESONIDE 2 MG RECTAL FOAM

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 weeks

OTHER CRITERIA

Patient has clinical information supporting: (1) Active, mild to moderate ulcerative colitis, and (2) Failure, contraindication, or intolerance to a one-month course of aminosalicylates (e.g., sulfasalazine, mesalamine).

UREA SPLITTING URINARY INFECTION

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LITHOSTAT

EXCLUSION CRITERIA

Pregnancy or SCr less than 20mL/min

REQUIRED MEDICAL INFORMATION

SCr is required. For women, pregnancy status is required. For continuation of therapy, CBC with reticulocyte count, platelet count, and white cell count within the past 30 days is required.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Medical justification which documents the plan for curative treatment with surgical removal of stones and antibiotic therapy. Or medical justification which documents why curative treatment is not appropriate.

VALTOCO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VALTOCO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information provided that the member is on existing antiepileptic therapy and is experiencing acute, intermittent, or frequent seizure activity.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

VENLAFAXINE BESYLATE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VENLAFAXINE BESYLATE ER

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information that member has been on at least 75 mg of another venlafaxine extended release product for at least 4 days.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification for why venlafaxine hcl extended release capsule or tablet could not be used.

VIBERZI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VIBERZI

EXCLUSION CRITERIA

Concurrent use of Lotronex, opioids, or anticholinergic medications.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Gastroenterology

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

VIJOICE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VIJOICE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information indicating (1) patient has at least one severe clinical manifestation of PROS (examples of severe clinical manifestations include excessive tissue growth, blood vessel malformations, scoliosis, vascular tumors, cardiac or renal manifestations, and those that require systemic treatment) AND (2) confirmation of PIK3CA mutation

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

VOCLOSPORIN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LUPKYNIS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: Labs showing eGFR is 45ml/min/1.73m² or higher and BP is less than 165/105. COC:
Documentation of positive clinical response to therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Nephrologist

COVERAGE DURATION

6 months

OTHER CRITERIA

Clinical information showing member is using mycophenolate mofetil (MMF) and a corticosteroid concurrently with Lupkynis.

VOSEVI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VOSEVI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

HCV RNA level within past 6 months

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA

Trial with preferred formulary alternative Mavyret where Mavyret regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. Patient is not concurrently taking any of the following medications not recommended by the manufacturer: 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 or tipranavir/ritonavir.

VRAYLAR

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

VRAYLAR

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification that two formulary alternatives (Aripiprazole, Olanzapine, Paliperidone, Quetiapine, Risperidone, Ziprasidone, or Rexulti) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

VTAMA

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

VTAMA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 weeks

OTHER CRITERIA

Medical justification specifying why tazarotene and calcipotriene could not be used.

VUITY

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VUITY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: physician statement for why corrective lenses could not be used. COC: physician statement documenting continued benefit with use and an improved vision related to reading performance

AGE RESTRICTION

Age 40-55

PRESCRIBER RESTRICTION

Optometrist or Ophthalmologist

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

VYNDAQEL

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VYNDAMAX, VYNDAQEL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Cardiology

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

WASTING

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

SEROSTIM

EXCLUSION CRITERIA

Using to enhance athletic performance or physique.

REQUIRED MEDICAL INFORMATION

Height, weight, body mass index (BMI), Body cell mass (BCM) by bioelectrical impedance analysis (BIA). Male recipients: a prescriber statement is required attesting treatment is not prescribed to enhance athletic performance or physique.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

For HIV-associated wasting, patients must have concomitant antiretroviral therapy and meet the following criteria. For HIV-associated wasting or cachexia associated with chronic disease: dose does not exceed FDA approved maximum and patient meets at least one of the following: weighs less than 90% ideal body weight, OR 10% or more unintentional weight loss within the preceding 12 months, OR 7.5% unintentional weight loss within the preceding six months, OR has a baseline BIA or total body DEXA showing body cell mass (BCM) below 40% in males and 35% in females, OR 5% BCM loss within the preceding six months, OR BMI less than 20 kg/m². Reauthorization: improvement or stabilization in the body weight or body cell mass (BCM) compared to baseline.

XCOPRI

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

XCOPRI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying that two formulary alternatives (Carbamazepine, Clorazepate, Felbamate, Gabapentin, Lamotrigine, Levetiracetam, Oxcarbazepine, Pregabalin, Tiagabine, Topiramate, Valproic Acid, Zonisamide) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

XELJANZ

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

XELJANZ, XELJANZ XR

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA

The member has a history of failure, contraindication, or reason(s) for intolerance to TNF blockers (e.g. Humira or Enbrel).

XERMELO

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

XERMELO

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 3 months. Continuation: 1 year

OTHER CRITERIA

For initial therapy: Individual is using in combination with somatostatin analog (SSA) therapy (such as but not limited to, lanreotide (Somatuline Depot), octreotide (Sandostatin)) AND individual has had an inadequate response on a stable dose of SSA monotherapy for at least 3 months. For continuation therapy: Individual has previously met the initiation criteria AND clinically significant improvements are confirmed after 12 weeks of treatment with Xermelo (telotristat ethyl) when added to SSA therapy.

XIFAXAN

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

XIFAXAN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 days for travelers diarrhea, 1 year for hepatic encephalopathy, or 3 months for IBS.

OTHER CRITERIA

For hepatic encephalopathy must first try lactulose or metronidazole or provide medical justification.

XOLAIR

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

XOLAIR

EXCLUSION CRITERIA

Non-allergic asthma.

REQUIRED MEDICAL INFORMATION

For IgE medicated allergic asthma: Perennial aeroallergen IgE levels, documented trial and failure of at least one inhaled corticosteroid (Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, or Mometasone). For chronic idiopathic urticaria: Medical justification that an H1 antihistamine has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

Maximum dose of 375mg every 2 weeks (for asthma) or 600mg every 2 weeks (for nasal polyps).

ZEPATIER

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ZEPATIER

EXCLUSION CRITERIA

Moderate or severe liver impairment (Child-Pugh B or C)

REQUIRED MEDICAL INFORMATION

HCV RNA level within past 6 months. For genotype 1A: testing for NS5A resistance-associated polymorphisms. Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA

Criteria will be applied consistent with current AASLD/IDSA guidance. Trial with preferred formulary alternative ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, or Mavyret where that regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. No approval for requests where provider attests that patient has life expectancy less than 12 months due to non-liver related comorbid conditions (per AASLD/IDSA treatment guideline recommendation). Patient is not concurrently taking any of the following: phenytoin, carbamazepine, rifampin, efavirenz, atazanavir, darunavir, lopinavir, saquinavir, tipranavir, cyclosporine, nafcillin, ketoconazole, modafinil, bosentan, etravirine, elvitegravir/cobicistat/emtricitabine/tenofovir, atorvastatin at doses above 20mg per day or rosuvastatin at doses greater than 10mg per day.

ZEPOSIA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ZEPOSIA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

MS: Trial of or contraindication to ONE sphingoside-1-phosphate receptor modulator and ONE other agent indicated for treatment of multiple sclerosis. Ulcerative colitis (UC): Trial of or contraindication to TWO of the following preferred agents: Humira, Rinvoq, Stelara or Xeljanz.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

ZORYVE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ZORYVE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification specifying why tazarotene and calcipotriene could not be used.

ZTALMY

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ZTALMY

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Clinical information confirming CDKL5 deficiency disorder

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A