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

2024 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 2024

(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 2024

(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 2024

(شرایط تأیید داروهای خاص)

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

2024 사전 승인 기준

(특정 의약품의 승인 조건)

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

معايير الحصول على تصريح مسبق لعام 2024

(متطلبات الموافقة على أدوية معينة)

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

2024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
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: RA, PJIA, SJIA, GCA, SSc-ILD: 6 months. CRS: 1 month. COC: 12 MONTHS.

OTHER CRITERIA
Initial- For Rheumatoid Arthritis (RA): One of the following: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz, Rinvoq, or (2) Trial of a TNF inhibitor and physician has indicated the patient cannot use a JAK inhibitor due to the black box warning (increased risk of mortality, malignancies, and serious CV events). For Polyarticular Juvenile Idiopathic Arthritis (PJIA): Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz IR. For Systemic Juvenile Idiopathic Arthritis (SJIA): Trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, or leflunomide. COC: Physician attestation that the patient continues to benefit from the medication.

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 10 MG GEL PUMP, 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 CYPIONATE, 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. For brand-name testosterone products, medical justification must be provided documenting why generic testosterone products cannot be used.

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 PEN, EMGALITY SYRINGE, EMGALITY 300 MG (100 MG X 3 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, AMPHOTERICIN B LIPOSOME, CASPOFUNGIN ACETATE, ERAXIS, 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, AUGTYRO 40 MG CAPSULE, BALVERSA, BESREMI, BOSULIF, CALQUENCE, COMETRIQ, COPIKTRA, DASATINIB, DAURISMO, ERLOTINIB HCL, FIRMAGON, FOTIVDA, FRUZAQLA, GAVRETO, GEFITINIB, GILOTRIF, ICLUSIG, IDHIFA, IMATINIB MESYLATE, INLYTA, INQOVI, INREBIC, IWILFIN, JAYPIRCA, KOSELUGO, KRAZATI, LAPATINIB, LAZCLUZE, LENALIDOMIDE, LONSURF, LORBRENA, LUMAKRAS 120 MG TABLET, LUMAKRAS 320 MG TABLET, LYTGOBI, NERLYNX, ODOMZO, OGSIVEO, OJJAARA, ONUREG, ORSERDU, PAZOPANIB HCL, PEMAZYRE, PIQRAY, QINLOCK, RETEVMO, REZLIDHIA, ROZLYTREK, SCEMBLIX, SORAFENIB, STIVARGA, SUNITINIB MALATE, TAGRISSO, TALZENNA, TASIGNA, TAZVERIK, TEPMETKO, TIBSOVO, TOREMIFENE CITRATE, TRUQAP, TUKYSA, TURALIO 125 MG CAPSULE, VANFLYTA, VENCLEXTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VORANIGO, WELIREG, XALKORI, XOSPATA, XPOVIO, XTANDI, ZEJULA 100 MG TABLET, ZEJULA 200 MG TABLET, ZEJULA 300 MG TABLET, ZYDELIG, ZYKADIA

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, Immunologist, Allergist

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 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, MEKINIST, MEKTOVI, NUBEQA, OJEMDA, ORGOVYX, TAFINLAR, TORPENZ, 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.

ARCALYST

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ARCALYST

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Cryopyrin-Associated Periodic Syndromes (CAPS)- (1) Genetic testing has confirmed a mutation in the IL1RN gene. Pericarditis- (1) Patient has recurrent pericarditis (history of at least three episodes of pericarditis). COC: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cryopyrin-Associated Periodic Syndromes: Prescriber by or in consultation with Rheumatology, Geneticist, Allergist/Immunology, or Dermatology. Deficiency of Interleukin-1 Receptor Antagonist: Prescriber by or in consultation with Rheumatology, Geneticist, Dermatologist, or a physician specializing in the treatment of autoinflammatory disorders. Pericarditis: Prescriber by or in consultation with Cardiology or Rheumatology.

COVERAGE DURATION
New: CAPS/Deficiency of Interleukin-1 Receptor Antagonist- 6 mos. Pericarditis- 3 mos. COC: 1 year.

OTHER CRITERIA
N/A

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
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Huntington Disease: Prescribed by or in consultation with a neurologist or movement disorder specialist. Tardive Dyskinesia: Prescribed by or in consultation with a neurologist, psychiatrist or movement disorder specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
Tardive dyskinesia: patient has a history of using agents that cause tardive dyskinesia.

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.

BEXAROTENE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BEXAROTENE

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

BIMZELX

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BIMZELX, BIMZELX AUTOINJECTOR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 PSO: Trial of or contraindication to two of the following preferred agents (where ages align): Humira, Simlandi, Cosentyx, Stelara, Enbrel, Skyrizi, Tremfya. COC: Physician attestation that the patient continues to benefit from the medication.

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 200 MG VIAL KIT, CIMZIA 2X200 MG/ML SYRINGE KIT, CIMZIA 2X200 MG/ML(X3)START KT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial- For Non-radiographic axial spondyloarthritis (NR-AXSPA): 1) C-reactive protein levels above the upper limit of normal, or 2) sacroiliitis on MRI. For Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 Rheumatoid Arthritis (RA): For Rheumatoid Arthritis (RA): One of the following: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz, Rinvoq, or (2) Trial of a TNF inhibitor and physician has indicated the patient cannot use a JAK inhibitor due to the black box warning (increased risk of mortality, malignancies, and serious CV events). For Psoriatic Arthritis (PSA): Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Xeljanz, Tremfya, Rinvoq, Skyrizi. For PSO: Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Skyrizi, Tremfya. For Ankylosing Spondylitis (AS): Trial of or contraindication to two of the following preferred agents: Enbrel, Humira, Simlandi, Cosentyx, Xeljanz, Rinvoq. For Crohns Disease (CD): Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Rinvoq, Stelara, Skyrizi. For

NR-AXSPA: Trial of or contraindication to two of the following preferred agents: Cosentyx, Rinvoq.
COC: Physician attestation that the patient continues to benefit from the medication.

CORLANOR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CORLANOR 5 MG/5 ML ORAL SOLN, IVABRADINE HCL

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, ACTHAR SELFJECT, 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
Initial- For Non-radiographic axial spondyloarthritis (NR-AXSPA): 1) C-reactive protein levels above the upper limit of normal, or 2) sacroiliitis on MRI. For Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 PSO: trial of or contraindication to one conventional therapy such as phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. For Psoriatic Arthritis (PSA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For Ankylosing Spondylitis (AS) / NR-AXSPA: trial of or contraindication to an NSAID. For Enthesitis-Related Arthritis (ERA): trial of or contraindication to an NSAID, sulfasalazine, or methotrexate. COC- For all indications: Physician attestation that the patient continues to benefit from the medication.

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 1 MG TABLET, GLIMEPIRIDE 2 MG TABLET, GLIMEPIRIDE 4 MG TABLET, 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 65 years of age or older.

AGE RESTRICTION
PA required for enrollees age 65 and over. No PA required for enrollees under age 65.

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)
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.

DAYBUE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DAYBUE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: Patient has a diagnosis of Rett syndrome (RTT) with generic analysis confirming mutation in the MECP2 gene.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Geneticist, Pediatric neurology, Neurology, Metabolic neurology

COVERAGE DURATION
Initial: 6 months, COC: 1 year.

OTHER CRITERIA
COC: Documentation of positive clinical response (as measured by an appropriate rating scale) to Daybue therapy.

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)
DICLOFENAC SODIUM 3% GEL, DOXEPIN 5% CREAM, TAZAROTENE 0.05% CREAM, TAZAROTENE 0.05% GEL, TAZAROTENE 0.1% GEL, 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 AND at least ONE oral formulary NSAID 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 x 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.

DRIZALMA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DRIZALMA 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 for why generic duloxetine delayed release capsule could not be used.

DRY EYE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
CYCLOSPORINE 0.05% EYE EMULS, EYSUVIS, 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, 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
Initial- For treatment of atopic dermatitis (AD): Body surface area (BSA) involvement equal to or greater than 10 percent or affecting crucial body areas such as the hands, feet, face, genitals, or intertriginous areas. For Eosinophilic esophagitis (EoE): Diagnosis confirmed by esophagogastroduodenoscopy (EGD) with biopsy. For Eosinophilic asthma: Blood eosinophil level greater than or equal to 150 cells/mcl within the past 12 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: AD, CRSwNP, EOE, PN- 6 months, Asthma- 4 months. COC: All indications- 12 months.

OTHER CRITERIA
Initial- For AD (in patients 2 years and older): (1) Trial of or contraindication to one topical (corticosteroid, calcineurin inhibitor, PDE4 inhibitor, or JAK inhibitor), and (2) No concurrent use of other systemic biological/JAK inhibitor for AD. 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 Asthma: (1) Concurrent therapy with a medium, high-dose or maximally-tolerated dose of an inhaled corticosteroid (ICS) and one other maintenance medication, (2) One asthma exacerbation requiring systemic corticosteroid burst lasting 3 or more days within the past 12 months, or one serious exacerbation requiring hospitalization or ER visit with the past 12 months, or poor symptom control despite current therapy as evidence by at least 3 of the following within the past 4 weeks: daytime asthma symptoms more than twice per week, any

night waking due to asthma, SABA reliever for symptoms more than twice per week, any activity limitations due to asthma, and (3) no concurrent use of Xolair or other Anti-IL5 biologics when used for asthma. For Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP): (1) evidence of nasal polyps, 2) inadequately controlled disease as determined by use of systemic steroids in the past 2 years or endoscopic sinus surgery, and (3) a 90-day trial of one topical nasal corticosteroid. For renewal- AD: Members condition is stable or showing clinical improvement. CRSwNP/EOE: Improvement while on therapy. PN: Improvement or reduction of pruritis or pruriginous lesions. Asthma: (1) no concurrent use of Xolair, or other anti-IL5 biologic for asthma, (2) continued use of ICS and one other maintenance medication, and (3) clinical response as evidence by: (A) reduction in asthma exacerbations from baselines, (B) decrease utilization of rescue medications, (C) increase in percent predicted FEV1from pretreatment baselines, or (D) reduction in severity or frequency of asthma-related symptoms. COC- All indications: Physician attestation that the patient continues to benefit from the medication.

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.

ELYXYB

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ELYXYB

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, or Headache/migraine specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification that at least ONE oral triptan has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

EMFLAZA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEFLAZACORT

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 (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 Rheumatoid arthritis (RA) / Polyarticular Juvenile Idiopathic Arthritis (PJIA)/ Psoriatic Arthritis (PSA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For Ankylosing Spondylitis (AS): trial of or contraindication to an NSAID. For PSO: trial of or contraindication to one conventional therapy such as phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. COC- All indications: Physician attestation that the patient continues to benefit from the medication.

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 relapse during the previous 12 months

ENZYME REPLACEMENTS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CYSTAGON, JAVYGTOR, RAVICTI, SAPROPTERIN DIHYDROCHLORIDE, SODIUM PHENYLBUTYRATE

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 PELLET PKT, EPCLUSA 200 MG-50 MG TABLET, EPCLUSA 200-50 MG PELLET 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.

FABHALTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FABHALTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Paroxysmal nocturnal hemoglobinuria diagnosis was confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-AP) demonstrated by: 1A) At least 5% PNH cells, or 1B) At least 21% GPI-AP poly-morphonuclear cells, and (2) Hemoglobin level of less than 10 g/dL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology

COVERAGE DURATION
Initial: 6 months. COC: 1 year.

OTHER CRITERIA
COC: Physician attestation that the patient continues to benefit from the medication.

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

FILSUVEZ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FILSUVEZ

EXCLUSION CRITERIA
Concurrent use with Vyjuvek

REQUIRED MEDICAL INFORMATION
Confirmation of a genetic mutation associated with DEB or JEB (i.e., COL7A1, LAMA3, LAMB3, LAMC2, COL17A1, ITGA6, ITGB4, ITGA3)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology, Wound care specialist

COVERAGE DURATION
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, 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, NUTROPIN AQ NUSPIN, OMNITROPE, SKYTROFA, SOGROYA, 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. [F] HBeAg negative, ALT at least 2XULN, HBV DNA below 2,000 IU/mL, evaluate ALT. [G] HBeAg negative, ALT above ULN but below 2XULN, HBV DNA above or below 2,000 IU/mL, evaluate ALT. [H] HBeAg negative, ALT below ULN, HBV DNA above 2,000 IU/mL, monitor. [I] 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 40 MG/0.8 ML SYRINGE, HUMIRA PEN, HUMIRA(CF), 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
New requests for Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 Rheumatoid arthritis (RA) / Polyarticular Juvenile Idiopathic Arthritis (PJIA)/ Psoriatic Arthritis (PSA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For Ankylosing Spondylitis (AS): trial of or contraindication to an NSAID. For PSO: trial of or contraindication to one conventional therapy such as phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. For Uveitis: no isolated anterior uveitis. For Crohns Disease (CD) / Ulcerative Colitis (UC): trial of or contraindication to one conventional therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. COC- All indications: Physician attestation that the patient continues to benefit from the medication.

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
For Plaque psoriasis (PSO): Psoriasis involving greater than or equal to 3% 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- For PSO: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Skyrizi, Tremfya. COC: Physician attestation that the patient continues to benefit from the medication.

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 1 MG TABLET, ISTURISA 5 MG TABLET

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, 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).Part B Prerequisite required.

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 x 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.

JOENJA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
JOENJA

EXCLUSION CRITERIA
(1) Member under 12 years or age, or (2) Member weight less than 45 kg.

REQUIRED MEDICAL INFORMATION
Initial: (1) Member weight, (2) Member has a genetic phosphoinositide 3-kinase delta mutation with a variant in PIK3CD and/or PIK3R1 genes, and (3) Member has clinical manifestations compatible with APDS (e.g., history of repeated oto-sino-pulmonary infections, lymphoproliferation, autoimmunity [e.g., cytopenia], enteropathy, organ dysfunction [e.g., lung, liver])

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Immunology, Pulmonology, Hematology or a physician who specializes in the treatment of APDS.

COVERAGE DURATION
Initial: 6 months, COC: 1 year

OTHER CRITERIA
COC: Member is experiencing benefit from therapy as evidenced by disease stability or disease improvement (e.g., reduced lymph node size, increased naïve B-cell percentage, decreased frequency or severity of infections, decreased frequency of hospitalizations).

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
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial- Rheumatoid Arthritis (RA): Prescribed by on in consultation with Rheumatology.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial- RA: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz, Rinvoq, or (2) Trial of a TNF inhibitor and physician has indicated the patient cannot use a JAK inhibitor due to the black box warning (increased risk of mortality, malignancies, and serious CV events). For Polyarticular Juvenile Idiopathic Arthritis (PJIA): Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz IR. COC: Physician attestation that the patient continues to benefit from the medication.

KINERET

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
KINERET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial- Rheumatoid Arthritis (RA): Prescribed by on in consultation with Rheumatology.

COVERAGE DURATION
Initial- RA: 6 months, All other indications: 12 months. COC: 12 months.

OTHER CRITERIA
Initial- RA: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz, Rinvoq, or (2) Trial of a TNF inhibitor and physician has indicated the patient cannot use a JAK inhibitor due to the black box warning (increased risk of mortality, malignancies, and serious CV events). COC: Physician attestation that the patient continues to benefit from the medication.

KORLYM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MIFEPRISTONE 300 MG TABLET

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.

LIBERVANT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LIBERVANT

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
Patient is 2 to 5 years of age.

PRESCRIBER RESTRICTION
Neurology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

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.

LITFULO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LITFULO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Documentation or record of at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT), and (2) Negative Tuberculosis (TB) test result.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology

COVERAGE DURATION
1 year

OTHER CRITERIA
Maximum dose of 50mg daily.

LOFEXIDINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LOFEXIDINE HCL

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.

LOKELMA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LOKELMA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) labs from within past 30 days showing hyperkalemia (potassium level above 5 mEq/L).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
(1) Medications known to cause hyperkalemia (ACEIs, ARBs, NSAIDs, aldosterone antagonists) have been discontinued or reduced to lowest effective dose, and (2) Medical justification specifying that sodium polystyrene sulfonate has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

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)
ACCUTANE 10 MG CAPSULE, ACCUTANE 20 MG CAPSULE, ACCUTANE 40 MG CAPSULE, 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, POMALYST, QUININE SULFATE, TETRABENAZINE, TRIDACAINE II, 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 40MG/ML 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.

MIGLUSTAT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MIGLUSTAT, YARGESA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Clinical information confirming Gaucher Disease Type 1 by ONE of the following: (a) deficient beta-glucocerebrosidase activity in leukocytes or fibroblasts OR (b) molecular genetic testing documenting glucocerebrosidase gene mutation AND evidence of ONE of the following: (a) anemia (hemoglobin level below testing laboratory's lower limit of the normal range based on age and gender OR (b) thrombocytopenia (platelet less than 100,000 per microliter) OR (c) hepatomegaly (as evidenced by increased liver volume upon radiological imaging OR (d) splenomegaly (as evidenced by increased spleen volume by radiological imaging) OR (e) growth failure (growth velocity below the standard mean for age) OR (f) evidence of bone disease with other causes ruled out. COC: Improvement in or stabilization from baseline of at least 1 of the following: decrease in spleen volume, decrease in liver volume, increase in hemoglobin level, increase in platelet count, improvement in growth or decrease in bone pain or crisis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Geneticist, endocrinologist or specialist in treatment of Gaucher disease.

COVERAGE DURATION
1 year

OTHER CRITERIA
For doses above 300 mg per day, documentation the dose is insufficient due to no clinical improvement in spleen volume, liver volume, hemoglobin level or platelet count AND creatinine clearance is above 70 ml/min/1.73m2 AND clinical information confirming no evidence of adverse reactions (peripheral neuropathy, tremors, diarrhea or decreased platelet counts).

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 Mycite.

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.

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

NEXLETOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NEXLETOL, NEXLIZET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Lipid panel 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-inducted 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.

NURTEC

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NURTEC ODT

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
New therapy: Acute migraine treatment: trial of or contraindication to one triptan (e.g., sumatriptan, rizatriptan). Episodic migraine prevention: 1) no concurrent use with other C-GRP inhibitors for migraine prevention, and 2) trial of or contraindication to one of the following preventive migraine treatments: divalproex sodium, topiramate, propranolol, timolol. Renewal: Acute migraine treatment: 1) Improvement from baseline in a validated acute treatment patient-reported outcome questionnaire, or 2) therapy works consistently in majority of migraine attacks. Episodic migraine Prevention: 1) no concurrent use with other C-GRP inhibitors for migraine prevention, and 2) reduction in migraine or headache frequency, migraine severity, or migraine duration with therapy.

NYMALIZE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
NYMALIZE 60 MG/ML ORAL SOLUTION

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial- Rheumatoid Arthritis (RA): Prescribed by on in consultation with Rheumatology.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial- RA: Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz, Rinvoq. COC: Physician attestation that the patient continues to benefit from the medication.

OMVOH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OMVOH 100 MG/ML SYRINGE, OMVOH PEN

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: For Ulcerative Colitis (UC)- Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Skyrizi, Stelara, Xeljanz, Rinvoq. COC: Physician attestation that the patient continues to benefit from the medication.

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.

OPSYNVI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OPSYNVI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Documentation of PAH diagnosis based on right heart catheterization and (2) WHO functional class II-III symptoms

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology or Pulmonology

COVERAGE DURATION
1 year

OTHER CRITERIA
New: Tried and failed ONE endothelin receptor antagonists (ERA) such as ambrisentan, bosentan or macitentan and ONE phosphodiesterase 5 inhibitor (PDE5I) such as sildenafil or tadalafil taken as single agents. Continuation: Documentation that the medication has been effective (i.e., member is stable on current dose and/or no evidence of disease progression).

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)
EPRONTIA, GLOPERBA, SEVELAMER 2.4 GM POWDER PACKET, SPIRONOLACTONE 25 MG/5 ML SUSP, VIGABATRIN 500 MG POWDER PACKT, VIGAFYDE, VIGPODER, 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
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial- RA/PJIA/PSA: 6 months. AGVHD: 12 months. COC: 12 months.

OTHER CRITERIA
Initial- For Rheumatoid Arthritis (RA): For Rheumatoid Arthritis (RA): One of the following: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz, Rinvoq, or (2) Trial of a TNF inhibitor and physician has indicated the patient cannot use a JAK inhibitor due to the black box warning (increased risk of mortality, malignancies, and serious CV events). For Polyarticular juvenile idiopathic arthritis (PJIA): Trial or contraindication to any TWO of the following preferred agents: Humira, Simlandi, Enbrel or Xeljanz. For Psoriatic Arthritis (PSA): Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Xeljanz, Tremfya, Rinvoq, Skyrizi. Renewal: Physician attestation that the patient continues to benefit from the medication.

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 10-20 MG STARTER 28 DAY, OTEZLA 10-20-30MG START 28 DAY, OTEZLA 20 MG TABLET, OTEZLA 30 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial- For Mild Plaque psoriasis (PSO): One of the following: (1) psoriasis involving greater than or equal to 2% of body surface area, (2) Static physician global assessment (SPGA) score of 2, or (3) Psoriasis area and severity index (PASI) score of 2 to 9. For Moderate to severe PSO: psoriasis involving greater than or equal to 3% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For Psoriatic Arthritis (PSA): Prescribed by or in consultation with Dermatology or Rheumatology. PSO: 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- For PSA: Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Xeljanz, Tremfya, Rinvoq, Skyrizi. For mild PSO: Trial of or contraindication to one conventional systemic agent (e.g., methotrexate, acitretin, cyclosporine) and one conventional topical agent (e.g., PUVA, UVB, topical corticosteroid). For moderate to severe PSO: Trial of or contraindication to two of the following preferred agents: Humira, Simlandi Cosentyx, Stelara, Enbrel, Skyrizi, Tremfya. For 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 treatment

(e.g., colchicine, topical corticosteroid, oral corticosteroid). COC: Physician attestation that the patient continues to benefit from the medication.

OXYBATE SALTS

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
SODIUM OXYBATE, 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, ALYQ, 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

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, 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

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, DIHYDROERGOTAMINE 4 MG/ML SPRY, DRONABINOL, ELMIRON, EMSAM, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, ERGOLOID MESYLATES, FINTEPLA, FLUCYTOSINE, GARDASIL 9, GLASSIA, HEPLISAV-B, ICATIBANT, KEVEYIS, L-GLUTAMINE 5 GRAM POWDER PKT, NUPLAZID, 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, ORMALVI, PHENOXYBENZAMINE HCL, PIRFENIDONE, PREHEVBRIO, PROLASTIN C, 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 1,000 MG VIAL

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, PROSOL, REGRANEX, SIRTURO, TOBI PODHALER, TRAVASOL, TRIENTINE HCL 250 MG CAPSULE, TROPHAMINE

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)

ASTAGRAF XL, 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, MYHIBBIN, 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 1 MG TABLET, RAPAMUNE 1 MG/ML ORAL SOLN, RAPAMUNE 2 MG TABLET, SANDIMMUNE 100 MG CAPSULE, 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.

PD

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, PERSERIS ER 90 MG SYRINGE KIT

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
For is allogenic hematopoietic stem cell transplant (HSCT), therapy will be initiated between day 0 and day 28 post-transplantation. For kidney transplant, therapy will be initiated between day 0 and day 7 post-transplantation. For continuation of treatment beyond 200 days, 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

PROMACTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PROMACTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For thrombocytopenia with persistent or chronic ITP New: (1) clinical information showing inadequate response or intolerant to corticosteroids, immunoglobulins or has undergone splenectomy and (2) platelet count at baseline is less than 30,000 platelets/microliter or platelet count at baseline is less than 50,000 platelets/microliter and patient has an increased risk for bleeding. For thrombocytopenia with chronic hepatitis C New: (1) patient will be receiving interferon-based therapy for chronic hepatitis C and (2) platelet count at baseline is less than 75,000 platelets/microliter. For aplastic anemia New: (1) clinical information showing inadequate response to immunosuppressive therapy or patient will be using eltrombopag with standard immunosuppressive therapy and (2) platelet count at baseline is less than 30,000 platelets/microliter (3) baseline labs for hemoglobin level and absolute neutrophil count.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ITP or Aplastic Anemia: hematologist or oncologist. Chronic hepatitis: gastroenterologist, hepatologist or specialist in infectious disease.

COVERAGE DURATION
ITP or Aplastic Anemia: 6 months. Chronic hepatitis C: 1 year

OTHER CRITERIA
For thrombocytopenia with persistent or chronic ITP COC: clinical information documenting beneficial response by increased platelet counts, maintenance of platelet counts or decreased frequency of bleeding episodes. For thrombocytopenia with chronic hepatitis C COC: (1) clinical information documenting positive clinical response and (2) patient continues to be on antiviral interferon therapy for chronic hepatitis C. For aplastic anemia COC: clinical information documenting a positive clinical

response such as increased platelet counts, reduction in blood transfusions, increase in hemoglobin and/or increase in absolute neutrophil count.

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

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

COVERAGE DURATION
1 year

OTHER CRITERIA
Evidence that patient is currently on riluzole or has tried riluzole in the past. Part B Prerequisite required.

RAYALDEE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RAYALDEE

EXCLUSION CRITERIA
Treatment of patients with secondary hyperparathyroidism with stage 5 chronic kidney disease or end-stage renal disease on dialysis.

REQUIRED MEDICAL INFORMATION
Labs within past 30 days showing serum total 25-hydroxyvitamin D level is less than 30 ng/mL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Patient has had previous treatment, intolerance, or contraindication to a generic vitamin D analog (i.e., ergocalciferol, cholecalciferol, or calcitriol).

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).

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

REZDIFFRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
REZDIFFRA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: confirmed diagnosis of MASH/NASH by (1) liver biopsy with evidence of stage F2 or F3 fibrosis and NAFLD Activity Score (NAS) of at least 4 OR (2) noninvasive tests including (2A) identification of liver steatosis by ultrasound, CT or MRI, and (2B) detection of advanced liver fibrosis via at least ONE of the following serological tests: (i) Fibrosis-4 (FIB-4) score 2.67 or more, or (ii) Enhanced Liver Fibrosis (ELF) test is 9.8 or more, AND (2C) ONE of the following noninvasive methods of imaging: (i) vibration-controlled transient elastography (VCTE) imaging of liver stiffness is 12kPa or more, or (ii) magnetic resonance elastography (MRE) of 3.63kPa or more. Noninvasive testing must be done within the past 12 months. COC: Clinical information or physician statement indicating there is no evidence of liver cirrhosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hepatology

COVERAGE DURATION
1 year

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, RINVOQ LQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial- For Non-radiographic axial spondyloarthritis (NR-AXSPA): 1) C-reactive protein levels above the upper limit of normal, or 2) sacroiliitis on MRI.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial- For Rheumatoid Arthritis (RA) and Psoriatic Arthritis (PSA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For Atopic Dermatitis (AD): 1) Atopic dermatitis covering at least 10 percent of body surface area or affecting the face, head, neck, hands, feet, groin, or intertriginous areas, 2) history of failure, contraindication, or reason(s) for intolerance to ONE of the following: topical corticosteroid, topical calcineurin inhibitors, topical PDE4 inhibitors, or topical JAK inhibitor, and 3) no concurrent use with other systemic biological/jak inhibitor for the treatment of AD. For Crohns Disease (CD) / Ulcerative Colitis (UC): trial of or contraindication to one conventional therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. For NR-AXSPA: trial of or contraindication to an NSAID. COC- For RA/PSA/AS/NR-AXSPA: Physician attestation that the patient continues to benefit from the medication. For AD: 1) Physician attestation that the patient continues to benefit from the medication, and 2) no concurrent use with other systemic biological/jak inhibitor for the treatment of AD.

RIVFLOZA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RIVFLOZA

EXCLUSION CRITERIA
Concurrent use with Oxlumo (lumasiran).

REQUIRED MEDICAL INFORMATION
New: (1A) Genetic test result showing a mutation in the alanine: glyoxylate aminotransferase (AGT or AGXT) gene or (1B) Liver biopsy confirming AGT enzyme deficiency, and (2) eGFR of greater than or equal to 30 mL/min/1.73 m2.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology, Genetics, or other healthcare provider who specializes in treating primary hyperoxaluria type 1 (PH1)

COVERAGE DURATION
New: 6 months, COC: 1 year

OTHER CRITERIA
COC: The patient has had a positive response to therapy (e.g., decrease or normalization in urinary and/or plasma oxalate levels, improvement in kidney function).

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
For Plaque psoriasis (PSO): Psoriasis involving greater than or equal to 3% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For PSO: Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial- For PSO: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Skyrizi, Tremfya. COC- For PSO: Physician attestation that the patient continues to benefit from the medication.

SIMLANDI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SIMLANDI(CF) AUTOINJECTOR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New requests for Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 Rheumatoid arthritis (RA) / Polyarticular Juvenile Idiopathic Arthritis (PJIA)/ Psoriatic Arthritis (PSA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For Ankylosing Spondylitis (AS): trial of or contraindication to an NSAID. For PSO: trial of or contraindication to one conventional therapy such as phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. For Uveitis: no isolated anterior uveitis. For Crohns Disease (CD) / Ulcerative Colitis (UC): trial of or contraindication to one conventional therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. COC- All indications: Physician attestation that the patient continues to benefit from the medication.

SIMPONI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SIMPONI

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- For Rheumatoid Arthritis (RA): For Rheumatoid Arthritis (RA): One of the following: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Enbrel, Xeljanz, Rinvoq, or (2) Trial of a TNF inhibitor and physician has indicated the patient cannot use a JAK inhibitor due to the black box warning (increased risk of mortality, malignancies, and serious CV events). For Psoriatic Arthritis (PSA): Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Xeljanz, Tremfya, Rinvoq, Skyrizi. For Ankylosing Spondylitis (AS): Trial of or contraindication to two of the following preferred agents: Enbrel, Humira, Simlandi, Cosentyx, Xeljanz, Rinvoq. For Ulcerative Colitis (UC): Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Skyrizi, Stelara, Xeljanz, Rinvoq. COC: Physician attestation that the patient continues to benefit from the medication.

SKYCLARYS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SKYCLARYS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Confirmed presence of a mutation in the frataxin (FXN) gene, and (2) Patient has been assessed using the modified Friedreich's Ataxia Rating Scale and has a score between 20 and 80.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Geneticist

COVERAGE DURATION
1 year

OTHER CRITERIA
COC: Documentation of positive clinical response to Skyclarys therapy.

SKYRIZI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SKYRIZI 150 MG/ML SYRINGE, SKYRIZI ON-BODY, SKYRIZI PEN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial- For Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 Psoriatic Arthritis (PSA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For PSO: trial of or contraindication to one conventional therapy such as phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. For Crohns Disease (CD) or Ulcerative Colitis (UC): trial of or contraindication to one conventional therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. COC- PSA/PSO: Physician attestation that the patient continues to benefit from the medication.

SNRI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FETZIMA, TRINTELLIX, 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.

SOHONOS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOHONOS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: (1) results of genetic test confirming mutation in activin A type 1 receptor (ACVR1) consistent with fibrodysplasia ossificans progressive (FOP) and (2) presence of heterotopic ossification (HO) as confirmed by radiologic testing such as X-ray, computed tomography (CT) , magnetic resonance imaging (MRI) or positron emission tomography (PET) scans COC: documentation of positive clinical response to therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist, Rheumatologist, Orthopedist, Geneticist or primary provider in consult with an FOP specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

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
For Plaque psoriasis (PSO): Psoriasis involving greater than or equal to 3% 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- For PSO: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Skyrizi, Tremfya. COC- For PSO: Physician attestation that the patient continues to benefit from the medication.

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
Initial- For Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 Psoriatic Arthritis (PSA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For PSO: trial of or contraindication to one conventional therapy such as phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. For Crohns Disease (CD) / Ulcerative Colitis (UC): trial of or contraindication to one conventional therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. COC- PSA/PSO: Physician attestation that the patient continues to benefit from the medication.

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, acarbose 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, TALTZ SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial- For Non-radiographic axial spondyloarthritis (NR-AXSPA): 1) C-reactive protein levels above the upper limit of normal, or 2) sacroiliitis on MRI. For Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 PSO: Trial of or contraindication to two of the following preferred agents (where ages align): Humira, Simlandi, Cosentyx, Stelara, Enbrel, Skyrizi, Tremfya. For Psoriatic Arthritis (PSA): Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Cosentyx, Stelara, Enbrel, Xeljanz, Tremfya, Rinvoq, Skyrizi. For Ankylosing Spondylitis (AS): Trial of or contraindication to two of the following preferred agents: Enbrel, Humira, Simlandi, Cosentyx, Xeljanz, Rinvoq. For NR-AXSPA: Trial of or contraindication to two of the following preferred agents: Cosentyx, Rinvoq. COC: Physician attestation that the patient continues to benefit from the medication.

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

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 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 x 10^9/L or UPCR of 1000 mg/g or higher or previous hypersensitivity reaction with use of Tegsedi

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 250 MG CAPSULE, TETRACYCLINE 500 MG CAPSULE

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

TIGLUTIK

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TEGLUTIK, TIGLUTIK

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 has tried riluzole tablet in the past

TIOPRONIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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.

TREMFYA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TREMFYA 100 MG/ML INJECTOR, TREMFYA 100 MG/ML SYRINGE, TREMFYA 200 MG/2 ML SYRINGE, TREMFYA PEN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial- For Plaque psoriasis (PSO): Moderate to severe psoriasis involving greater than or equal to 3% 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 Psoriatic Arthritis (PSA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For PSO: trial of or contraindication to one conventional therapy such as phototherapy ultraviolet light A (PUVA), ultraviolet light B (UVB), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. COC- All indications: Physician attestation that the patient continues to benefit from the medication.

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 16 MCG CARTRIDGE, TYVASO DPI 16-32-48 MCG TITRAT, TYVASO DPI 32 MCG CARTRIDGE, TYVASO DPI 32-48 MCG MAINT KIT, TYVASO DPI 48 MCG CARTRIDGE, TYVASO DPI 64 MCG CARTRIDGE

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

VELSIPITY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VELSIPITY

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial- UC: 6 months, COC: 12 months

OTHER CRITERIA
Initial: For Ulcerative Colitis (UC)- Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Skyrizi, Stelara, Xeljanz, Rinvoq. COC: Physician attestation that the patient continues to benefit from the medication.

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.

VEOZAH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VEOZAH

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Menopausal Vasomotor Symptoms (VMS): Initial- (1) Experiences 7 or more hot flashes per day, and (2) Medical justification that one hormonal therapy (such as estradiol transdermal patch, oral conjugated estrogens, micronized progesterone) has been tried and failed or are contraindicated, or would not be medically appropriate for the patient. COC- Reduction in VMS frequency or severity due to Veozah treatment.

VERQUVO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VERQUVO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Heart Failure (HF)- Initial: Trial of or contraindication to (1) one agent from any of the following standard of care classes: A) ACE inhibitor, ARB, or ARNI, B) Beta blocker (i.e., bisoprolol, carvedilol, metoprolol succinate), or C) Aldosterone antagonist (i.e., spironolactone, eplerenone), and (2) one SGLT-2 inhibitors. Initial/renewal: not concurrently taking long-acting nitrates, Adempas, or PDE-5 inhibitors.

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 1.5 MG CAPSULE, VRAYLAR 3 MG CAPSULE, VRAYLAR 4.5 MG CAPSULE, VRAYLAR 6 MG CAPSULE

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

WAINUA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
WAINUA

EXCLUSION CRITERIA
Wainua is not being used in combo with Amvuttra, Onpattro, Tegsedi, or a tafamidis product (Vyndamax, Vyndaqel).

REQUIRED MEDICAL INFORMATION
New: (1) Diagnosis confirmed by detection of a mutation in the TTR gene, (2) Patient has symptomatic polyneuropathy (e.g., peripheral/autonomic neuropathy, motor disability, cardiovascular dysfunction, renal dysfunction) (3) Member is not a liver transplant recipient, (4) Documentation confirming the presence of polyneuropathy characterized by either (4A) Baseline polyneuropathy disability (PND) score less than or equal to IIIb, (4B) Baseline familial amyloid polyneuropathy (FAP) Stage 1 or 2, or (4C) Neuropathy impairment (NIS) score of at least 10 but no more than 130.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Genetics

COVERAGE DURATION
New: 6 months. COC: 1 year

OTHER CRITERIA
COC: Response to treatment (e.g., improvement of neuropathy severity and rate of disease progression as demonstrated by the modified Neuropathy Impairment Scale+7 (mNIS+7) composite score, the Norfolk Quality of Life-Diabetic Neuropathy (QoL-DN) total score, polyneuropathy disability (PND) score, FAP disease stage, manual grip strength)

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.

WEGOVY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
WEGOVY

EXCLUSION CRITERIA
Part D does not cover this drug when used for treatment of obesity.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

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.

XDEMVY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
XDEMVY

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Results of either standardized skin surface biopsy (SSSB) or direct microscopic examination (DME).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
One 10mL bottle per 365 days

OTHER CRITERIA
N/A

XELJANZ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
XELJANZ, XELJANZ XR

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- For Rheumatoid Arthritis (RA) / Psoriatic Arthritis (PSA) / Polyarticular Course Juvenile Idiopathic Arthritis (PCJIA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. For Ankylosing Spondylitis (AS): trial of or contraindication to an NSAID. For Ulcerative Colitis (UC): trial of or contraindication to one conventional therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. COC- All indications: Physician attestation that the patient continues to benefit from the medication.

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).

ZAVZPRET

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZAVZPRET

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) CGRP- Ubrelvy, or Nurtec ODT, (2) Triptans- sumatriptan, rizatriptan/rizatriptan ODT, naratriptan, or zolmitriptan/zolmitriptan ODT. COC: Documentation of positive clinical response to therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
New: 6 months. COC: 1 year

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

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
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial- Ulcerative Colitis (UC): Prescribed by or in consultation with gastroenterology.

COVERAGE DURATION
Initial- Multiple Sclerosis (MS): 12 months. UC: 6 months, COC: 12 months

OTHER CRITERIA
Initial- MS: Trial of one sphingosine-1 phosphate receptor modulator (e.g., Gilenya, Mayzent) and any one agent indicated for the treatment of MS. UC: Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Skyrizi, Stelara, Xeljanz, Rinvoq.

ZILBRYSQ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZILBRYSQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial- (1) Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy, (2) Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score 6 or more at initiation of therapy, and (3A) History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.), or (3B) Patient has a history of failure of at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/ plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control. COC- Clinical improvement demonstrated by (1) Improvement and/or maintenance of at least a 3-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology

COVERAGE DURATION
1 year

OTHER CRITERIA
Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or a neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart, Vyvgart Hytrulo). Part B Prerequisite required

ZORYVE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ZORYVE 0.3% CREAM, ZORYVE 0.3% FOAM

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.

ZORYVE-AD

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ZORYVE 0.15% CREAM

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Atopic Dermatitis: Medical justification specifying why one topical corticosteroid or topical calcineurin inhibitor 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

ZURZUVAE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZURZUVAE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
14 days

OTHER CRITERIA
N/A