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

2027 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 2027

(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 2027

(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 2027

(شرایط تأیید داروهای خاص)

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

2027 사전 승인 기준

(특정 의약품의 승인 조건)

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

معايير الحصول على تصريح مسبق لعام 2027

(متطلبات الموافقة على أدوية معينة)

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

2027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。

Критерии для получения предварительного разрешения на 2027 г.

(Требования для получения одобрения на определенные лекарственные препараты.)

Пожалуйста, прочитайте! Этот документ содержит информацию о препаратах, покрываемых этим планом.

A1-ANTITRYPSIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PROLASTIN C

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ABALOPARATIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ABEMACICLIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VERZENIO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ABIRATERONE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ABIRATERONE ACETATE, ABIRTEGA, YONSA

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ABIRATERONE-NIRAPARIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AKEEGA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PENDING CMS APPROVAL

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ABSSSI 2 WEEK

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DALBAVANCIN HCL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 weeks

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ABSSSI 6 DAY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SIVEXTRO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 days

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACALABRUTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
CALQUENCE 100 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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ACTIMMUNE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ACTIMMUNE

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACYCLOVIR

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML 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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ACYCLOVIR-TOP

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ACYCLOVIR 5% CREAM, ACYCLOVIR 5% OINTMENT

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ADAGRASIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
KRAZATI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ADALIMUMAB

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ADALIMUMAB-AATY(CF), ADALIMUMAB-AATY(CF) AI CROHNS, ADALIMUMAB-AATY(CF) AUTOINJECT, ADALIMUMAB-FKJP(CF), ADALIMUMAB-FKJP(CF) PEN, HADLIMA, HADLIMA(CF), HADLIMA(CF) PUSHTOUCH, HADLIMA PUSHTOUCH

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: HS: 1 year. All other indications: 6 months. COC: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ADEFOVIR

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ADEFOVIR DIPIVOXIL

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

AFATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GILOTRIF

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AFICAMTEN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MYQORZO

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, and (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 20 mg per day

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ALECTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ALECENSA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ALOSETRON

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ALOSETRON HCL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ALPELISIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
PIQRAY

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AMBRISENTAN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AMBRISENTAN

EXCLUSION CRITERIA
N/A

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

AMIKACIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ARIKAYCE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
Documented failure with a multidrug background regimen therapy.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

AMITRIPTYLINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AMITRIPTYLINE HCL

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AMITRIPTYLINE-PERPHENAZINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PERPHENAZINE-AMITRIPTYLINE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AMPH-DEXT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEXTROAMPHETAMINE-AMPHETAMINE, 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

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AMPHOTERICINB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AMPHOTERICIN B

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AMPHOTERICINB-LIP

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AMPHOTERICIN B LIPOSOME

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months (1 year if immunocompromised)

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ANDEMBRY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ANDEMBRY AUTOINJECTOR

EXCLUSION CRITERIA
Age less than 12 years old

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an Allergist, Immunologist, or physician who specializes in the treatment of HAE

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ANIDULAFUNGIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ERAXIS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months (1 year if immunocompromised)

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

APALUTAMIDE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ERLEADA

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

APREPITANT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
APREPITANT

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

APTIOM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ESLICARBAZEPINE ACETATE

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

AQNEURSA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AQNEURSA

EXCLUSION CRITERIA
Weight less than 15 kg.

REQUIRED MEDICAL INFORMATION
(1) Diagnosis has been genetically confirmed by mutation analysis of NPC1 and NPC2 genes, and (2) Not used in combination with Miplyffa.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Niemann-Pick disease type C (NPC)- Initial: Prescribed by or in consultation with Neurology or Genetics.

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

OTHER CRITERIA
COC- For NPC: (1) Improvement or slowing of disease progression.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
PENDING CMS APPROVAL

COVERAGE DURATION
PENDING CMS APPROVAL

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ARFORMOTEROL

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ARFORMOTEROL TARTRATE

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ARMODAFINIL

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ARMODAFINIL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ASCIMINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
SCEMBLIX

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ASENAPINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ASENAPINE MALEATE, SECUADO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatry

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ATOVAQUONE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ATOVAQUONE

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ATROPINE-DIPHENOXYLATE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DIPHENOXYLATE-ATROPINE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AUVELITY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AUVELITY ER 45-105 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

AVAPRITINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AYVAKIT

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AVIB-CEFT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AVYCAZ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

AVONEX

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AVONEX, AVONEX (4 PACK), AVONEX PEN, AVONEX PEN (4 PACK)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AVUTOMETINIB-DEFACTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AVMAPKI-FAKZYNJA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AXITINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
INLYTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

AZACITIDINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ONUREG

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BAXDELA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BAXDELA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious disease

COVERAGE DURATION
2 weeks

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BEDAQUILINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SIRTURO

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BELIMUMAB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BELZUTIFAN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
WELIREG

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BEMPEDOIC

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NEXLETOL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BEMPEDOIC-EZETIMIBE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NEXLIZET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BESIFLOXACIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BESIFLOXACIN HCL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BESREMI

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BESREMI, BESREMI PEN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BETAINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BETAINE ANHYDROUS

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BETASERON

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BETASERON 0.3 MG INJECTION

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BINIMETINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
MEKTOVI

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BOSENTAN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BOSENTAN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BOSUTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BOSULIF 100 MG CAPSULE, BOSULIF 100 MG TABLET, BOSULIF 500 MG TABLET, BOSULIF 50 MG CAPSULE, BOSUTINIB 400 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BREXPIPRAZOLE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
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

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. Rexulti will not require prior therapy when being used for agitation associated with dementia in Alzheimer's disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PENDING CMS APPROVAL

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BRIGATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ALUNBRIG

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BRINSUPRI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BRINSUPRI

EXCLUSION CRITERIA
Age less than 12 years old

REQUIRED MEDICAL INFORMATION
Diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by high-resolution chest CT scan.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by, or in consultation with, pulmonology or infectious disease specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
COC: Physician attestation that the patient has experienced a beneficial clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BRIVARACETAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BRIVARACETAM 100 MG TABLET, BRIVARACETAM 10 MG/ML ORAL SOL, BRIVARACETAM 10 MG TABLET, BRIVARACETAM 25 MG TABLET, BRIVARACETAM 50 MG TABLET, BRIVARACETAM 75 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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BRUKINSA

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BRUKINSA 160 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
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

BUTALBITAL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BUTALBITAL-ACETAMINOPHEN-CAFFEINE 50-325-40 MG TABLET

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CABLIVI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CABLIVI 11 MG VIAL KIT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CABOZANTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
COMETRIQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CALCIPOTRIENE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CALCIPOTRIENE 0.005% CREAM, CALCIPOTRIENE 0.005% OINTMENT, CALCIPOTRIENE 0.005% SOLUTION

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CALCIUMACETATE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
CALCIUM ACETATE 667 MG CAPSULE, CALCIUM ACETATE 667 MG GELCAP

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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CANNABIDIOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EPIDIOLEX 100 MG/ML SOLUTION

EXCLUSION CRITERIA
Age less than 1 years old

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CAPIVASERTIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TRUQAP

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PENDING CMS APPROVAL

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CARBAGLU

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CARGLUMIC ACID

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CASPOFUNGIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CASPOFUNGIN ACETATE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months (1 year if immunocompromised)

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CAYSTON

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CAYSTON

EXCLUSION CRITERIA
Age less than 7 years old

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CEDAZURIDINE-DECITABINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
INQOVI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CEFTOLOZANE-TAZOBACTAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZERBAXA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CERITINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ZYKADIA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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. COC: 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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

CILOXAN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CIMZIA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CIMZIA 2X200 MG/ML SYRINGE KIT, CIMZIA (2 PACK), CIMZIA (2 PACK)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CINRYZE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CINRYZE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an Allergist, Immunologist, or physician who specializes in the treatment of HAE

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CLINIMIX

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

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CLINIMIX-E

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CLINISOL-PROSOL-PLEAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CLINISOL, PLENAMINE, PROSOL

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CLINOLIPID

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CLINOLIPID

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CLOBAZAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CLOBAZAM, SYMPAZAN

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CLOMIPRAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CLOMIPRAMINE HCL

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

COBIMETINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
COTELLIC

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CORLANOR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
IVABRADINE HCL

EXCLUSION CRITERIA
PENDING CMS APPROVAL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CORTICOTROPIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
CORTROPHIN, 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
YES

PREREQUISITE THERAPY REQUIRED

YES

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial- HS: 1 year, All other indications: 6 months. COC- 1 year.

OTHER CRITERIA
Initial- For PSO: (1) One of the following: (i) trial of at least a 3 month trial of one oral immunosuppressant (cyclosporine, methotrexate, tacrolimus), or PUVA (phototherapy) for the treatment of PSO, (ii) Contraindication or intolerance to both immunosuppressant and PUVA therapy, or (iii) Patient is switching from a different biologic, PDE-4 inhibitor, or JAK inhibitor for PSO. For NR-AXSPA/Ankylosing Spondylitis (AS): (1) Trial 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. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

CRENESSITY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CRENESSITY 100 MG CAPSULE, CRENESSITY 50 MG CAPSULE

EXCLUSION CRITERIA
Member under 4 years of age.

REQUIRED MEDICAL INFORMATION
(1) Member has a diagnosis of classic CAH confirmed by ONE of the following (1A) elevated 17-hydroxyprogesterone, (1B) confirmed CYP21A2 genotype, (1C) positive newborn screening with confirmatory second-tier testing, OR (1D) diagnostic results after cosyntropin stimulation, and (2) the medication will be taken in combination with a systemic glucocorticoid (e.g. hydrocortisone, prednisone, prednisolone, dexamethasone).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
The medication is prescribed by or in consultation with endocrinology, or a physician who specializes in the treatment of adrenal hyperplasia.

COVERAGE DURATION
1 year

OTHER CRITERIA
COC: Documentation that the member continues to benefit from the medication (e.g., reduced androstenedione levels, decreased 17-hydroxyprogesterone, or reduction in glucocorticoid dose from baseline)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CRESEMBA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CRESEMBA 186 MG CAPSULE, CRESEMBA 74.5 MG CAPSULE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Fungal culture and sensitivity (C&S) results within 60 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an infectious disease specialist

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
Medical justification specifying that ONE applicable formulary alternative (Voriconazole, Posaconazole, Amphotericin B injection, Caspofungin injection, or Anidulafungin injection) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CRIZOTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
XALKORI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

CROTAMITON

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CROTAN, PRURADIK

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CTEXLI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CTEXLI

EXCLUSION CRITERIA
Age less than 18 years old.

REQUIRED MEDICAL INFORMATION
Diagnosis is established by both of the following: (A) a molecular genetic test demonstrating a pathogenic variant in the CYP27A1 gene, AND (B) lab result demonstrating elevated serum cholestanol levels.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with Neurology, Metabolic Specialists, or Genetics

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

OTHER CRITERIA
New: baseline ALT, AST, and bilirubin. COC: (1) ALT, AST, and bilirubin within the past 6 months and (2) Physician attestation that the patient continues to benefit from the medication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYCLOBENZAPRINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYPROHEPTADINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CYPROHEPTADINE HCL

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYSTARAN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CYSTARAN

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

CYSTEAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CYSTAGON

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DABRAFENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TAFINLAR

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DALFAMPRIDINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DALFAMPRIDINE ER

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DAROLUTAMIDE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
NUBEQA

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DASATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DASATINIB, PHYRAGO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DAWNZERA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DAWNZERA

EXCLUSION CRITERIA
Age less than 12 years old

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an Allergist, Immunologist, or physician who specializes in the treatment of HAE

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DAYBUE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DAYBUE STIX

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEFERASIROX

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
PENDING CMS APPROVAL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEFERIPRONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEFERIPRONE, DEFERIPRONE (3 TIMES A DAY), FERRIPROX 100 MG/ML SOLUTION

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
PENDING CMS APPROVAL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEFLAZACORT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEFLAZACORT, JAYTHARI, KYMBEE, PYQUVI

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
1 year

OTHER CRITERIA
Member must have tried and failed or have a contraindication or intolerance to Prednisone. For continuation: Physician attestation that the patient is showing improvement or slowing of disease progression.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DEGARELIX

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FIRMAGON

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEMECLOCYCLINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DEMECLOCYCLINE HCL

EXCLUSION CRITERIA
PENDING CMS APPROVAL

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DESIPRAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DESIPRAMINE HCL

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DESVENLAFAXINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DESVENLAFAXINE ER

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEUTETRABENAZINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AUSTEDO, AUSTEDO XR, AUSTEDO XR TITR(12-18-24-30MG)

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEXTROAMPHETAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEXTROAMPHETAMINE 10 MG TAB, DEXTROAMPHETAMINE 5 MG TAB, DEXTROAMPHETAMINE SULFATE ER

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DIAGNOSTIC USE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ATROPINE 1% EYE DROP

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DIAZOXIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DIAZOXIDE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DICHLORPHENAMIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DICHLORPHENAMIDE, ORMALVI

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DICLOFENAC

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DICLOFENAC EPOLAMINE, DICLOFENAC 1.5% TOPICAL SOLN, DICLOFENAC 2% SOLUTION PUMP

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Documentation that at least ONE oral formulary NSAID has been tried and failed within the previous 6 months. COC: 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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DICYCLOMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DICYCLOMINE 10 MG/5 ML SOLN, DICYCLOMINE 10 MG CAPSULE, DICYCLOMINE 20 MG TABLET

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DIHYDROERGOTAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DIHYDROERGOTAMINE 4 MG/ML SPRY

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DIMETHYLFUMARATE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DIMETHYL FUMARATE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DOPTELET

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DOPTELET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
ITP: 1 year. Other: 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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DORDAVIPRONE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
MODEYSO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DOXEPIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DOXEPIN 5% 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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DRONABINOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DRONABINOL 10 MG CAPSULE, DRONABINOL 2.5 MG CAPSULE, DRONABINOL 5 MG CAPSULE

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DULAGLUTIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TRULICITY

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DUPIXENT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DUPIXENT PEN, DUPIXENT 200 MG/1.14 ML SYRING, DUPIXENT 300 MG/2 ML SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PENDING CMS APPROVAL

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

DUVELISIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
COPIKTRA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DUVYZAT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DUVYZAT

EXCLUSION CRITERIA
(1) Concurrent use with exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vondys 53 (golodirsen)], (2) Patient has received gene therapy for DMD [e.g., Elevidys (delandistrogene moxparvovec-rokl)].

REQUIRED MEDICAL INFORMATION
Initial: (1A) Confirmed presence of a mutation in the DMD gene or (1B) Muscle biopsy documenting absent dystrophin, (2) Clinical signs and symptoms of DMD (e.g., proximal muscle weakness, Gowers's maneuver, elevated serum creatine kinase level), (3) Patient is ambulatory, and (4) Baseline evaluation with one of the following standardized assessments of motor function: 4 Standard Stairs (4SC) Climb, Rise From Floor, Total North Star Ambulatory Assessment (NSAA), or Six-minute walk test (6MWT).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy and/or neuromuscular disorders.

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

OTHER CRITERIA
COC: (1) Physician attestation that the patient would benefit from continued administration.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

EFLAPEGRASTIM

MEDICATION(S)

ROLVEDON

PENDING CMS APPROVAL

EFLORNITHINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
IWILFIN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EGRIFTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EGRIFTA WR

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Lipodystrophy due to HIV: 1 year. COC: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ELACESTRANT

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ORSERDU

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ELAMIPRETIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FORZINITY

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Results of genetic test confirming diagnosis of Barth syndrome (presence of TAFAZZIN mutation or MLCL/CL ratio of 0.30 or higher)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with cardiology, genetics, metabolic specialist, or neurology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ELMIRON

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ELMIRON

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

EMPAVELI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EMPAVELI

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology, or Nephrology

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENASIDENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
IDHIFA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial- For Rheumatoid arthritis (RA): (1) previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug). For Ankylosing Spondylitis (AS): (1) trial of or contraindication to an NSAID. For PSO: (1) One of the following: (i) trial of at least a 3 month trial of one oral immunosuppressant (cyclosporine, methotrexate, tacrolimus), or PUVA (phototherapy), (ii) Contraindication or intolerance to both immunosuppressant and PUVA, or (iii) Patient is switching from a different biologic, PDE-4 inhibitor, or JAK inhibitor for PSO. For COC- All indications: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

ENCORAFENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BRAFTOVI 75 MG CAPSULE

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENGERIX-B

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENSARTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ENSACOVE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENTRECTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ROZLYTREK

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ENTYVIO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ENTYVIO PEN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial: For Ulcerative Colitis (UC)- (1) Trial of or contraindication to two of the following preferred agents: Imuldosa/Otulfi/Steqeyma/Yesintek, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq, Skyrizi, Tremfya. For Crohns Disease (CD): (1) Trial of or contraindication to two of the following preferred agents: Imuldosa/Otulfi/Steqeyma/Yesintek, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Rinvoq, Skyrizi, Tremfya. COC: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ENZALUTAMIDE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
XTANDI

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EPCLUSA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOFOSBUVIR-VELPATASVIR

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EPOETIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
PROCRIT 10,000 UNIT/ML VIAL, PROCRIT 20,000 UNITS/ML VIAL, PROCRIT 2,000 UNITS/ML VIAL, PROCRIT 3,000 UNITS/ML VIAL, PROCRIT 40,000 UNITS/ML VIAL, PROCRIT 4,000 UNIT/ML VIAL, 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
Anemia due to chronic kidney disease or zidovudine: 1 year. Other: 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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERDAFITINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BALVERSA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERENUMAB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AIMOVIG AUTOINJECTOR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ERLOTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ERLOTINIB HCL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ESZOPICLONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ESZOPICLONE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ETRIPAMIL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CARDAMYST

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

EUCRISA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EUCRISA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
For patients over 2 years of age: Medical justification as to why topical corticosteroids or topical calcineurin inhibitors cannot be used.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

EVEROLIMUS

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
EVEROLIMUS 10 MG TABLET, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 2 MG TAB FOR SUSP, EVEROLIMUS 3 MG TAB FOR SUSP, EVEROLIMUS 5 MG TAB FOR SUSP, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, TORPENZ

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FASENRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FASENRA, FASENRA PEN

EXCLUSION CRITERIA
Excluded under Part D if meets coverage criteria under Part B. (Syringe will be reviewed under Part B).

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

FEDRATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
INREBIC

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FENFLURAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FINTEPLA

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FILGRASTIM

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GRANIX 300 MCG/0.5 ML SAFE SYR, GRANIX 300 MCG/0.5 ML SYRINGE, GRANIX 300 MCG/ML VIAL, GRANIX 480 MCG/0.8 ML SAFE SYR, GRANIX 480 MCG/0.8 ML SYRINGE, NEUPOGEN, NIVESTYM, RELEUKO 300 MCG/0.5 ML SYRINGE, RELEUKO 480 MCG/0.8 ML SYRINGE, ZARXIO

EXCLUSION CRITERIA
Neutrophil count higher than 100,000/mm3.

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PENDING CMS APPROVAL

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FILSPARI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FILSPARI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology

COVERAGE DURATION
Initial: 9 months, COC: 1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FINGOLIMOD

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FINGOLIMOD

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FLUCYTOSINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FLUCYTOSINE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FLUOROURACIL

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FLUOROURACIL 2% TOPICAL SOLN, FLUOROURACIL 5% TOPICAL SOLN

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FLUTAMIDE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
EULEXIN

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FREMANEZUMAB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AJOVY AUTOINJECTOR, AJOVY AUTOINJECTOR (3 PACK), AJOVY SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FRUQUINTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FRUZAQLA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

FUTIBATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LYTGOBI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GALCANEZUMAB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
EMGALITY PEN, EMGALITY SYRINGE, EMGALITY 300 MG (100 MG X 3 SYRINGE)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GEFITINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GEFITINIB

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GEPIRONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EXXUA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GEPOTIDACIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BLUJEPA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GILTERITINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
XOSPATA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GIMOTI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GIMOTI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical justification specifying why a generic metoclopramide product cannot be used.

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GLASDEGIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DAURISMO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLATIRAMER

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GLATIRAMER ACETATE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLATOPA

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GLATOPA

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLIMEPIRIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GLIMEPIRIDE 1 MG TABLET, GLIMEPIRIDE 2 MG TABLET, GLIMEPIRIDE 4 MG TABLET

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLUTAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
L-GLUTAMINE 5 GRAM POWDER PKT

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLYBURIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GLYBURIDE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLYBURIDE-METFORMIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GLYBURIDE-METFORMIN HCL

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GLYCEROLPHENYLBUTYRATE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GLYCEROL 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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

GRANISETRON

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GRASTEK

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GRASTEK

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

GROWTH HORMONE ANTAGONISTS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOMAVERT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HAEGARDA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
HAEGARDA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an Allergist, Immunologist, or physician who specializes in the treatment of HAE

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HARLIKU

MEDICATION(S)

HARLIKU

PENDING CMS APPROVAL

HBV-VACCINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RECOMBIVAX HB 10 MCG/ML VIAL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HEPLISAV-B

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
HEPLISAV-B

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HETLIOZ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TASIMELTEON

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HIGH POTENCY ER OPIOID

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MORPHINE SULFATE ER 100 MG CAP, MORPHINE SULFATE ER 120 MG CAP, MORPHINE SULF ER 100 MG TABLET, MORPHINE SULF ER 200 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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HPV-VACCINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GARDASIL 9

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HYDROXYZINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
HYDROXYZINE 2 MG/ML ORAL SOLUTION, HYDROXYZINE 10 MG/5 ML SOLN, HYDROXYZINE 50 MG/25 ML CUP, HYDROXYZINE HCL 10 MG TABLET, HYDROXYZINE HCL 25 MG TABLET, HYDROXYZINE HCL 50 MG TABLET, HYDROXYZINE PAMOATE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HYFTOR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
HYFTOR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IBERDOMIDE

MEDICATION(S)

ZENBEXUS

PENDING CMS APPROVAL

IBRUTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
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

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ICATIBANT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ICATIBANT, SAJAZIR

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ICOTYDE

MEDICATION(S)

ICOTYDE

PENDING CMS APPROVAL

ILOPERIDONE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FANAPT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatry

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

IMATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
IMATINIB MESYLATE, IMKELDI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Systemic mastocytosis: Allergy/Immunology, or Hematology/Oncology. Other Dx: Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IMIPRAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
IMIPRAMINE HCL

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INAVOLISIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ITOVEBI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INLURIYO

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
INLURIYO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying that one of the formulary endocrine therapy alternatives (e.g. tamoxifen, toremifene) have been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

INTRALIPID-NUTRILIPID

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
INTRALIPID, NUTRILIPID

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ISOTRETINOIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ACCUTANE 10 MG CAPSULE, ACCUTANE 20 MG CAPSULE, ACCUTANE 40 MG CAPSULE, AMNESTEEM, CLARAVIS, ISOTRETINOIN 10 MG CAPSULE, ISOTRETINOIN 20 MG CAPSULE, ISOTRETINOIN 30 MG CAPSULE, ISOTRETINOIN 40 MG CAPSULE, ZENATANE

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IVACAFTOR-LUMACAFTOR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ORKAMBI

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IVIG

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GAMMAGARD LIQUID, GAMMAGARD LIQUID ERC, GAMMAGARD S-D, GAMUNEX-C 1 GRAM/10 ML VIAL

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

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PENDING CMS APPROVAL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

IVOSIDENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TIBSOVO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
YES

PREREQUISITE THERAPY REQUIRED
YES

JADENU

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEFERASIROX 180 MG TABLET, DEFERASIROX 360 MG TABLET, DEFERASIROX 90 MG TABLET

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

JASCAYD

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
JASCAYD

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonology

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification that nintedanib and pirfenidone have been tried and failed, is contraindicated, or is not medically appropriate for the patient.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

JOENJA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
JOENJA 70 MG TABLET

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 naive B-cell percentage, decreased frequency or severity of infections, decreased frequency of hospitalizations).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

JOURNAVX

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
JOURNAVX

EXCLUSION CRITERIA
(1) Member under 18 years of age, (2) Concomitant use with strong CYP3A inhibitors, (3) Member with severe hepatic impairment (Child-Pugh Class C), (4) Member with severe renal impairment (eGFR less than 15mL/min), and (5) Treatment of chronic pain (defined as pain lasting one month duration or greater).

REQUIRED MEDICAL INFORMATION
(1) Medication will not be used for longer than 14 days for any acute pain occurrence, and (2) Patient has a history of intolerance or contraindication to a prescription NSAIDs.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

JYNARQUE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TOLVAPTAN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KERENDIA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
KERENDIA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For Chronic kidney disease associated with type 2 diabetes: (1) Receiving concurrent therapy with an angiotensin converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB) at maximally tolerated labeled dosage (unless contraindicated), or provide a medical justification as to why therapy would not be medically appropriate (e.g., intolerance). For risk reduction related to cardiovascular death, hospitalization for heart failure, and urgent heart failure visits: (1) heart failure with left ventricular ejection fraction (LVEF) of at least 40%.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

KEVZARA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
KEVZARA 150 MG/1.14 ML PEN INJ, KEVZARA 200 MG/1.14 ML PEN INJ, KEVZARA 200 MG/1.14 ML SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial- Rheumatoid Arthritis (RA) / Polyarticular Juvenile Idiopathic Arthritis (PJIA): Prescribed by on in consultation with Rheumatology.

COVERAGE DURATION
Initial- Polymyalgia Rheumatica (PMR): 1 year, All other indications: 6 months. COC: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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: 1 year. COC: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

KRISTALOSE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
KRISTALOSE, LACTULOSE 10 GM PACKET, LACTULOSE 20 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
PENDING CMS APPROVAL

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

KYGEVVI

MEDICATION(S)

KYGEVVI

PENDING CMS APPROVAL

LACTATE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AMMONIUM LACTATE

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAMIVUDINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LAMIVUDINE 100 MG TABLET, LAMIVUDINE 100 MG TABLET

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LAPATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LAPATINIB

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAROTRECTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VITRAKVI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LAZERTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LAZCLUZE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LECANEMAB

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LEQEMBI IQLIK 360 MG/1.8 ML

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
PENDING CMS APPROVAL

PRESCRIBER RESTRICTION
Prescribed by or in consultation with neurology, geriatrics, or psychiatry.

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

OTHER CRITERIA
Not experiencing any severe, unstable, or symptomatic amyloid-related imaging abnormalities, intracerebral hemorrhage, or hypersensitivity reactions while on therapy.

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
N/A

LECANEMAB-SD

MEDICATION(S)

LEQEMBI IQLIK 500 MG DOSE-2 AI

PENDING CMS APPROVAL

LENALIDOMIDE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LENALIDOMIDE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LEQSELVI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LEQSELVI

EXCLUSION CRITERIA
Concurrent use of other JAK inhibitors, biologic immunomodulators, cyclosporine, other potent immunosuppressants, or moderate or strong CYP2C9 inhibitors

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification that Litfulo and Olumiant have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LEUPROLIDE

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, LUPRON DEPOT, LUPRON DEPOT (LUPANETA)

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LEVALBUTEROL

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LEVOMILNACIPRAN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FETZIMA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LIDOCAINE-PAT

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LIDOCAINE 5% PATCH

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LINEZOLID

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LINEZOLID, LINEZOLID-D5W

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LITFULO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LITFULO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LOARGYS

MEDICATION(S)

LOARGYS

PENDING CMS APPROVAL

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LOMUSTINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LOMUSTINE

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LONAPEGSOMATROPIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SKYTROFA

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LORLATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LORBRENA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

LUMATEPERONE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
CAPLYTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatry

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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, and (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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MECASERMIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
INCRELEX

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MECHLORETHAMINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VALCHLOR

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MEGESTROL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MEGESTROL 20 MG TABLET, MEGESTROL 400 MG/10ML SUSP CUP, 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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MEROPENEM-VABORBACTAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VABOMERE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 weeks

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

METHADONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
METHADONE 10 MG/5 ML SOLUTION, METHADONE 5 MG/5 ML SOLN CUP, 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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

METHYLPHENIDATE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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/5 ML SOL, METHYLPHENIDATE 10 MG TABLET, METHYLPHENIDATE 20 MG TABLET, METHYLPHENIDATE 5 MG/5 ML SOLN, METHYLPHENIDATE 5 MG TABLET, 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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

METHYLTESTOSTERONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
METHYLTESTOSTERONE

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MIGLUSTAT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MIGLUSTAT, YARGESA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MIPLYFFA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MIPLYFFA

EXCLUSION CRITERIA
Age less than 2 years old.

REQUIRED MEDICAL INFORMATION
(1) Diagnosis has been genetically confirmed by mutation analysis of NPC1 and NPC2 genes, (2) Prescribed in combination with miglustat, and (3) Not receiving in combination with Aqneursa.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Niemann-Pick disease type C (NPC)- Initial: Prescribed by or in consultation with Neurology or Genetics.

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

OTHER CRITERIA
Initial- For patients weighing at least 15kg: Medical justification specifying that Aqneursa has been tried and failed, is contraindicated, or would not be medically appropriate for the patient. COC- For NPC: (1) Improvement or slowing of disease progression, and (2) prescribed in combination with miglustat.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MIRAMETINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GOMEKLI

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
Oncology, Transplant or infectious disease specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

MITAPIVAT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AQVESME

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MODAFINIL

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
MODAFINIL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MOMELOTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
OJJAARA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
1 year

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

NAFARELIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
SYNAREL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NERATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
NERLYNX

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NEREUS

MEDICATION(S)

NEREUS

PENDING CMS APPROVAL

NIACIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NIACIN ER

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

NILOTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DANZITEN, NILOTINIB D-TARTRATE, NILOTINIB HCL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NINTEDANIB

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NINTEDANIB ESYLATE, OFEV

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonology, or Rheumatology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NIRAPARIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ZEJULA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NIROGACESTAT

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
OGSIVEO 100 MG TABLET, OGSIVEO 150 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

NUCALA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NUCALA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial- Asthma: blood eosinophils of greater than or equal to 150 cells/mcL within part 12 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial- CRSwNP: 6 months. All other Dx: 1 year. COC: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

NUEDEXTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEXTROMETHORPHAN HBR-QUINIDINE

EXCLUSION CRITERIA
PENDING CMS APPROVAL

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. COC: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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. COC: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

NYMALIZE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
NIMODIPINE 60 MG/20 ML SOLN, 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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OCTREOTIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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 500 MCG/ML AMP, OCTREOTIDE ACET 500 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ODACTRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ODACTRA

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OLANZAPINE-SAMIDORPHAN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LYBALVI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatry

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OLAPARIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LYNPARZA

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OLEZARSEN

MEDICATION(S)

TRYNGOLZA

PENDING CMS APPROVAL

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. Alopecia Areata (AA): Prescribed by on in consultation with Dermatology.

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

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OLUTASIDENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
REZLIDHIA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OMVOH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OMVOH 200 MG/2 ML SYRINGE, OMVOH 300 MG DOSE - 2 SYRINGES, OMVOH 200 MG/2 ML PEN, OMVOH 300 MG DOSE - 2 PENS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial: For Ulcerative Colitis (UC)- (1) Trial of or contraindication to two of the following preferred agents: Imuldosa/Otulfi/Steqeyma/Yesintek, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq, Skyrizi, Tremfya. For Crohns Disease (CD): (1) Trial of or contraindication to two of the following preferred agents: Imuldosa/Otulfi/Steqeyma/Yesintek, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Rinvoq, Skyrizi, Tremfya. COC: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ONAPGO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ONAPGO

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology

COVERAGE DURATION
1 year

OTHER CRITERIA
NEW: (1) Medical justification specifying that adjunctive agents from at least TWO of the following different drug classes: (A) dopamine agonists, (B) catechol-O-methyltransferase (COMT) inhibitors, (C) monoamine oxidase type B (MAO-B) inhibitors, have been tried and failed, are contraindicated, or would not be medically appropriate for the patient. COC: Physician attestation that the patient continues to benefit from the medication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

OPIPZA

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
OPIPZA

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 Aripiprazole tablets and Aripiprazole disintegrating tablets could not be used.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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: 1 month. COC: 1 year.

OTHER CRITERIA
Initial- For Rheumatoid Arthritis (RA): (1) previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug). COC: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ORIAHNN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ORIAHNN

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
BMD measurement within the past 3 months

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ORPHENADRINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ORPHENADRINE CITRATE 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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OSIMERTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TAGRISSO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OTEZLA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OTEZLA 10-20-30MG START 28 DAY, OTEZLA 10-20 MG STARTER 28 DAY, OTEZLA 20 MG TABLET, OTEZLA 30 MG TABLET, OTEZLA XR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial- For mild PSO: (1) Trial of or contraindication to one conventional systemic agent (e.g., methotrexate, acitretin, cyclosporine) or one conventional topical agent (e.g., PUVA, UVB, topical corticosteroid). For moderate to severe PSO: (1) One of the following: (i) trial of at least 3 month of one oral immunosuppressant (cyclosporine, methotrexate, tacrolimus), or PUVA (phototherapy) for the treatment of PSO, (ii) Contraindication or intolerance to both immunosuppressant and PUVA therapy, or (iii) Patient is switching from a different biologic, PDE-4 inhibitor, or JAK inhibitor for PSO. 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. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

OXAZEPAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OXAZEPAM

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

OXYBATE SALTS

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
SODIUM OXYBATE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PACRITINIB

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VONJO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PALBOCICLIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
IBRANCE 100 MG TABLET, IBRANCE 125 MG CAPSULE, IBRANCE 125 MG TABLET, IBRANCE 75 MG TABLET

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PANCREATIC ENZYME

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CREON, PERTZYE, VIOKACE, ZENPEP

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PARICALCITOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PARICALCITOL 1 MCG CAPSULE, PARICALCITOL 2 MCG CAPSULE, PARICALCITOL 4 MCG CAPSULE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PAROXETINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PAROXETINE HCL

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PART D VS PART B

MEDICATION(S)

AZASAN, AZATHIOPRINE, CELLCEPT 200 MG/ML ORAL SUSP, CELLCEPT 250 MG CAPSULE, CELLCEPT 500 MG TABLET, CINACALCET HCL, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG TABLET, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE MODIFIED, ENVARSUS XR, EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, EVEROLIMUS 1 MG TABLET, GENGRAF 100 MG CAPSULE, GENGRAF 25 MG CAPSULE, 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, PULMOZYME, SANDIMMUNE 100 MG CAPSULE, SANDIMMUNE 25 MG CAPSULE, SIROLIMUS, 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), TACROLIMUS XL, 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.

PAZOPANIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
PAZOPANIB HCL 200 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PCSK9

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
REPATHA SURECLICK, REPATHA SYRINGE

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PEGASYS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PEGASYS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
48 WEEKS

OTHER CRITERIA
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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PEGFILGRASTIM

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FULPHILA, FYLNETRA, NEULASTA 6 MG/0.6 ML SYRINGE, NYVEPRIA, STIMUFEND, ZIEXTENZO

EXCLUSION CRITERIA
Neutrophil count higher than 100,000/mm3.

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PEMIGATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
PEMAZYRE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PENCICLOVIR

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
PENCICLOVIR

EXCLUSION CRITERIA
Herpes zoster.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 MONTH

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PEXIDARTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TURALIO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PHENOXYBENZAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PHENOXYBENZAMINE HCL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PHENYLBUTYRATE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PIMAVANSERIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NUPLAZID

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PIMECROLIMUS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PIMECROLIMUS

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PIRFENIDONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PIRFENIDONE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PIRTOBRUTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
JAYPIRCA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PLOZASIRAN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
REDEMPLO

EXCLUSION CRITERIA
(1) Under 18 years of age.

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with Endocrinology, Gastroenterology, or Lipidology.

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

OTHER CRITERIA
Initial: medical justification that Tryngolza has been tried and failed or would not be medically appropriate for the patient. COC: documentation supporting positive clinical response (such as a reduction in TG level from baseline or reduction in acute pancreatitis episodes).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

POMALIDOMIDE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
POMALYST

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PONATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ICLUSIG

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

POSACONAZOLE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
POSACONAZOLE 200 MG/5 ML SUSP, POSACONAZOLE DR 100 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months (1 year if immunocompromised)

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PRALSETINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GAVRETO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PREGABALIN-ER

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, 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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PREMASOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PREMASOL

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PENDING CMS APPROVAL

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PROB-SULO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ORLYNVAH

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PROLIA-BS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BILDYOS, CONEXXENCE, PROLIA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PROMACTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ELTROMBOPAG OLAMINE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PROMETHAZINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PROMETHAZINE 12.5 MG/10 ML CUP, PROMETHAZINE 12.5 MG TABLET, PROMETHAZINE 25 MG TABLET, PROMETHAZINE 50 MG TABLET, PROMETHAZINE 6.25 MG/5 ML CUP, PROMETHAZINE 6.25 MG/5 ML SOLN, PROMETHAZINE 6.25 MG/5 ML SYRP

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PYLERA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BISMUTH-METRONIDAZOLE-TETRACYC

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PENDING CMS APPROVAL

COVERAGE DURATION
10 days

OTHER CRITERIA
(1) Medical justification supports inability to use the individual components (i.e., generic bismuth suncitrate, metronidazole, tetracycline) concurrently (e.g., contraindications to the excipients)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

PYRIMETHAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PYRIMETHAMINE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PYRUKYND

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PYRUKYND 20 MG TABLET, PYRUKYND 50 MG TABLET, PYRUKYND 5 MG TABLET, PYRUKYND

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology

COVERAGE DURATION
New: 24 weeks. COC: 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

QBREXZA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
QBREXZA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

QUININE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
QUININE SULFATE

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

QUIZARTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VANFLYTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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
N/A

PREREQUISITE THERAPY REQUIRED
YES

RALDESY

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
RALDESY

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 provided that oral trazodone tablets are not appropriate or otherwise contraindicated.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
PENDING CMS APPROVAL

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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RECOMBIVAX

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RECOMBIVAX HB 10 MCG/ML SYR, RECOMBIVAX HB 40 MCG/ML VIAL, RECOMBIVAX HB 5 MCG/0.5 ML SYR, RECOMBIVAX HB 5 MCG/0.5 ML VL

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REGORAFENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
STIVARGA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RELACORILANT

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LIFYORLI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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 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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RELUGOLIX

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ORGOVYX

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REPOTRECTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AUGTYRO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REVUMENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
REVUFORJ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

REZDIFFRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
REZDIFFRA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hepatology, Gastroenterology

COVERAGE DURATION
1 year

OTHER CRITERIA
Initial: Medical justification for why injectable Wegovy could not be used.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RIBAVIRIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
RIBAVIRIN 200 MG CAPSULE, RIBAVIRIN 200 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Hep C: Per current AASLD/IDSA guidance. Hep B: 16 weeks. Other: 1 year.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RIBOCICLIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
KISQALI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
The member is being treated in combination with (1) an aromatase therapy (e.g., anastrozole, letrozole, exemestane), or (2) fulvestrant (Faslodex).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RINVOQ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RINVOQ, RINVOQ LQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RIOCIGUAT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ADEMPAS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

RIPRETINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
QINLOCK

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RUCAPARIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RUFINAMIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RUFINAMIDE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

RUXOLITINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
JAKAFI, JAKAFI XR

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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, Allergist

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SAMSCA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TOLVAPTAN 15 MG TABLET, TOLVAPTAN 30 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(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 (3) 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
PENDING CMS APPROVAL

COVERAGE DURATION
3 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SAPHNELO

MEDICATION(S)

SAPHNELO 120 MG/0.8 ML SYRINGE, SAPHNELO PEN

PENDING CMS APPROVAL

SAPROPTERIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
JAVYGTOR, SAPROPTERIN DIHYDROCHLORIDE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SARGRAMOSTIM

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LEUKINE

EXCLUSION CRITERIA
Neutrophil count higher than 100,000/mm3.

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SAVELLA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MILNACIPRAN HCL 100 MG TABLET, MILNACIPRAN HCL 12.5 MG TABLET, MILNACIPRAN HCL 25 MG TABLET, MILNACIPRAN HCL 50 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
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SCOPOLAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SCOPOLAMINE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SELEGILINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EMSAM

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SELINEXOR

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
XPOVIO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SELPERCATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
RETEVMO 120 MG TABLET, RETEVMO 160 MG TABLET, RETEVMO 40 MG TABLET, RETEVMO 80 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SELUMETINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
KOSELUGO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SEMAGLUTIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OZEMPIC, 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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SEVABERTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
HYRNUO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SEVELAMER

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
SEVELAMER CARBONATE 800 MG TAB, SEVELAMER HCL

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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SIBEPRENLIMAB

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VOYXACT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology

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

OTHER CRITERIA
Medical justification that Vanrafia have been tried and failed or would not be medically appropriate for the patient.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SILDENAFIL-PAH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SILDENAFIL, SILDENAFIL 10 MG/ML ORAL SUSP, SILDENAFIL 20 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SILIQ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SILIQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
Initial- For PSO: (1) Trial of or contraindication to two of the following preferred agents: Cosentyx, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Imuldosa/Otulfi/Steqeyma/Yesintek, Skyrizi, Tremfya, Otezla, and (2) No concurrent use of another small biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for PSO. COC- For PSO: Physician attestation that the patient continues to benefit from the medication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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. COC: 1 year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SINEQUAN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DOXEPIN 100 MG CAPSULE, DOXEPIN 10 MG CAPSULE, DOXEPIN 10 MG/ML ORAL CONC, DOXEPIN 150 MG CAPSULE, DOXEPIN 25 MG CAPSULE, DOXEPIN 50 MG CAPSULE, DOXEPIN 75 MG CAPSULE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Genetics

COVERAGE DURATION
1 year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SKYRIZI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SKYRIZI 150 MG/ML SYRINGE, SKYRIZI 55 MG/0.37 ML SYRINGE, SKYRIZI ON-BODY, SKYRIZI ON-BODY, SKYRIZI PEN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial- For PSO: (1) One of the following: (i) trial of at least a 3 month trial of one oral immunosuppressant (cyclosporine, methotrexate, tacrolimus), or PUVA (phototherapy) for the treatment of PSO, (ii) Contraindication or intolerance to both immunosuppressant and PUVA, or (iii) Patient is switching from a different biologic, PDE-4 inhibitor, or JAK inhibitor for PSO. COC- Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SOHONOS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOHONOS 10 MG CAPSULE, SOHONOS 1.5 MG CAPSULE, SOHONOS 1 MG CAPSULE, SOHONOS 5 MG CAPSULE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SOLARAZE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DICLOFENAC SODIUM 3% GEL

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SOMAPACITAN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOGROYA

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SOMATROPIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GENOTROPIN, HUMATROPE 12 MG CARTRIDGE, HUMATROPE 24 MG CARTRIDGE, HUMATROPE 6 MG CARTRIDGE, NORDITROPIN FLEXPRO 10 MG/1.5, NORDITROPIN FLEXPRO 15 MG/1.5, NORDITROPIN FLEXPRO 5 MG/1.5, OMNITROPE, ZOMACTON 5 MG VIAL

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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SONIDEGIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ODOMZO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SORAFENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
SORAFENIB

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SORIATANE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ACITRETIN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a dermatologist.

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SOTORASIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LUMAKRAS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SOTYKTU

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOTYKTU

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psoriasis: prescribed by or in consultation with a dermatologist.

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

OTHER CRITERIA
Initial- For PSO: (1) Trial of or contraindication to two of the following preferred agents: Cosentyx, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Imuldosa/Otulfi/Steqeyma/Yesintek, Skyrizi, Tremfya, Otezla. For Psoriatic Arthritis (PSA): (1) Trial of or contraindication to two of the following preferred agents: Cosentyx, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Imuldosa/Otulfi/Steqeyma/Yesintek, Xeljanz IR/XR, Rinvoq, Skyrizi, Tremfya, Orencia, Otezla. COC- Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SPEVIGO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SPEVIGO 150 MG/ML SYRINGE, SPEVIGO 300 MG/2 ML SYRINGE

EXCLUSION CRITERIA
(1) SAPHO syndrome, (2) Weight less than 40kg

REQUIRED MEDICAL INFORMATION
(1) No current active infection, (2) Weight

AGE RESTRICTION
12 years of age or older.

PRESCRIBER RESTRICTION
Generalized pustular psoriasis (GPP): Prescribed by or in consultation with Dermatology

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

STIRIPENTOL

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DIACOMIT

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SUNITINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
SUNITINIB MALATE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SUSP-COLCHICINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GLOPERBA

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SUSP-ERYTHROMYCIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ERYTHROMYCIN 200 MG/5 ML SUSP, ERYTHROMYCIN 400 MG/5 ML SUSP

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 formulation cannot be used.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SUSP-LAMOTRIGINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SUBVENITE 10 MG/ML SUSPENSION

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SUSP-SEVELAMER

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SEVELAMER 0.8 GM POWDER PACKET, SEVELAMER 2.4 GM POWDER PACKET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SUSP-TOPIRAMATE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TOPIRAMATE 25 MG/ML SOLUTION

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SUSP-VIGABATRIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VIGABATRIN 500 MG POWDER PACKT, VIGAFYDE

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SUSP-ZONISAMIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

SYMDEKO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SYMDEKO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TACROLIMUS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TADALAFIL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TADALAFIL 2.5 MG TABLET, TADALAFIL 5 MG TABLET

EXCLUSION CRITERIA
(1) Treatment of erectile/sexual dysfunction, (2) Concomitant use of nitrate-based drugs (nitroglycerin) for heart conditions.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Urology

COVERAGE DURATION
26 weeks

OTHER CRITERIA
For initial therapy: Clinical documentation indicates the patient has symptomatic BPH. For continued therapy: clinical documentation indicates a reduction in symptoms.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TADALAFIL-PAH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ALYQ, TADALAFIL 20MG TABLET (ADCIRCA GENERIC), TADLIQ

EXCLUSION CRITERIA
N/A

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TAKHZYRO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TAKHZYRO 150 MG/ML SYRINGE, TAKHZYRO 300 MG/2 ML SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an Allergist, Immunologist, or physician who specializes in the treatment of HAE

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TALAZOPARIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TALZENNA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PENDING CMS APPROVAL

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TALETRECTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
IBTROZI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TALICIA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TALICIA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Trial of a generic, guideline recommended, first-line regimen for H. pylori infection such as clarithromycin triple therapy (proton pump inhibitor (PPI) + clarithromycin + amoxicillin or metronidazole) or bismuth quadruple therapy (PPI + bismuth subcitrate or subsalicylate + tetracycline + metronidazole).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PENDING CMS APPROVAL

COVERAGE DURATION
14 days

OTHER CRITERIA
(1) Medical justification supports inability to use the individual components (i.e., generic rifabutin, amoxicillin, omeprazole) concurrently (e.g., contraindications to the excipients)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TALTZ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TALTZ 80 MG/ML AUTOINJECTOR, TALTZ 80 MG/ML AUTOINJECTOR, TALTZ 80 MG/ML AUTOINJECTOR, TALTZ 80 MG/ML SYRINGE, TALTZ SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial- For PSO: (1) Trial of or contraindication to two of the following preferred agents: Cosentyx, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Imuldosa/Otulfi/Steqeyma/Yesintek, Skyrizi, Tremfya, Otezla. For Psoriatic Arthritis (PSA): Trial of or contraindication to two of the following preferred agents: Cosentyx, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Imuldosa/Otulfi/Steqeyma/Yesintek, Xeljanz IR/XR, Rinvoq, Skyrizi, Tremfya, Orencia, Otezla. For Ankylosing Spondylitis (AS): (1) Trial of or contraindication to two of the following preferred agents: Cosentyx, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq. For NR-AXSPA: (1) Trial of or contraindication to two of the following preferred agents: Cosentyx, Rinvoq, Cimzia. COC: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

TARPEYO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TARPEYO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology or Immunology

COVERAGE DURATION
10 months

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TASCENSO

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TASCENSO ODT

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TAVNEOS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TAVNEOS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
YES

PREREQUISITE THERAPY REQUIRED
YES

TAZAROTENE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TAZAROTENE 0.05% CREAM, TAZAROTENE 0.05% GEL, TAZAROTENE 0.1% CREAM, TAZAROTENE 0.1% GEL

EXCLUSION CRITERIA
Cosmetic use.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Psoriasis/Acne: 1 year. Other: 3 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
1 year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TEFAMIDIS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VYNDAMAX

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TEMAZEPAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TEMAZEPAM 15 MG CAPSULE, TEMAZEPAM 30 MG CAPSULE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TENOFOVIR

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VEMLIDY

EXCLUSION CRITERIA
PENDING CMS APPROVAL

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TEPOTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TEPMETKO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TERIFLUNOMIDE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TERIFLUNOMIDE

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TERIPARATIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BONSITY, TERIPARATIDE

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
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TESTOSTERONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, 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
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TETRABENAZINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TETRABENAZINE

EXCLUSION CRITERIA
PENDING CMS APPROVAL

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TEZEPELUMAB

MEDICATION(S)

TEZSPIRE 210 MG/1.91 ML PEN

PENDING CMS APPROVAL

THALOMID

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
THALOMID 100 MG CAPSULE, THALOMID 50 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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TIGECYCLINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TIGECYCLINE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TIGLUTIK

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TIGLUTIK 50 MG/10 ML SUSP

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TIOPRONIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TIOPRONIN, VENXXIVA

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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TIPIRACIL-TRIFLURIDINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LONSURF

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TIRZEPATIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MOUNJARO

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TIVOZANIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FOTIVDA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOBI PODHALER

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TOBI PODHALER

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PENDING CMS APPROVAL

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOREMIFENE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TOREMIFENE CITRATE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOVORAFENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
OJEMDA

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRAMETINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
MEKINIST

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRAVASOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TRAVASOL

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TREMFYA

COVERED USES
All FDA-Approved Indications

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial- For PSO: (1) One of the following: (i) trial of at least a 3 month trial of one oral immunosuppressant (cyclosporine, methotrexate, tacrolimus), or PUVA (phototherapy) for the treatment of PSO, (ii) Contraindication or intolerance to both immunosuppressant and PUVA, or (iii) Patient is switching from a different biologic, PDE-4 inhibitor, or JAK inhibitor for PSO. COC- All indications: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TREPROSTINIL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ORENITRAM ER, ORENITRAM MONTH 1 TITRATION KT, ORENITRAM MONTH 2 TITRATION KT, ORENITRAM MONTH 3 TITRATION KT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TRETINOIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRIAZOLAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TRIAZOLAM

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRIENTINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TRIENTINE HCL 250 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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRIKAFTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TRIKAFTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TRIPTORELIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TROPHAMINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TROSPIUM-XANOMELINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
COBENFY, COBENFY STARTER PACK

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatry

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

TUCATINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TUKYSA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TYENNE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TYENNE 162 MG/0.9 ML SYRINGE, TYENNE AUTOINJECTOR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial- For Rheumatoid Arthritis (RA): One of the following: (1) Trial of or contraindication to two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq, Orencia. For Giant Cell Arteritis (GCA): (1) Has completed, stated, or will soon start a tapering course of glucocorticoids, and (2) Trial of or contraindication to the preferred agent: Rinvoq. For Polyarticular Juvenile Idiopathic Arthritis (PJIA): (1) Trial of or contraindication to two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Orencia, Rinvoq. COC: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

TYRVAYA

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TYRVAYA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

UBRELVY

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
UBRELVY

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

USTEKINUMAB

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
IMULDOSA 45 MG/0.5 ML SYRINGE, IMULDOSA 90 MG/ML SYRINGE, OTULFI 45 MG/0.5 ML SYRINGE, OTULFI 90 MG/ML SYRINGE, STEQEYMA 45 MG/0.5 ML SYRINGE, STEQEYMA 45 MG/0.5 ML VIAL, STEQEYMA 90 MG/ML SYRINGE, YESINTEK 45 MG/0.5 ML SYRINGE, YESINTEK 45 MG/0.5 ML VIAL, YESINTEK 90 MG/ML SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial- For PSO: (1) One of the following: (1A) trial of at least a 3 month trial of one oral immunosuppressant (cyclosporine, methotrexate, tacrolimus), or PUVA (phototherapy) for the treatment of PSO, (1B) Contraindication or intolerance to both immunosuppressant and PUVA, or (1C) Patient is switching from a different biologic, PDE-4 inhibitor, or JAK inhibitor for PSO. COC- Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

VALBENAZINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
INGREZZA, INGREZZA INITIATION PK(TARDIV), INGREZZA SPRINKLE

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VALTOCO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VALTOCO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VANRAFIA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VANRAFIA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology

COVERAGE DURATION
Initial: 9 months. COC: 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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: 1 year.

OTHER CRITERIA
Initial: For UC: (1) Trial of or contraindication to two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Imuldosa/Otulfi/Steqeyma/Yesintek, Rinvoq, Skyrizi, Tremfya. COC: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VEMURAFENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VENETOCLAX

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VENCLEXTA, VENCLEXTA, VENCLEXTA STARTING PACK

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VENLAFAXINE BESYLATE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VENLAFAXINE BESYLATE ER

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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/COC: not concurrently taking Adempas, or PDE-5 inhibitors.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VILAZODONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VILAZODONE HCL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VIMSELTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ROMVIMZA

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VISMODEGIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ERIVEDGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VOQUEZNA-2

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VOQUEZNA DUAL PAK

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of H. Pylori

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 weeks

OTHER CRITERIA
Trial of a generic, guideline recommended, first-line regimen for H. pylori infection such as clarithromycin triple therapy (proton pump inhibitor (PPI) + rifabutin + amoxicillin) or bismuth quadruple therapy (PPI + bismuth subcitrate or subsalicylate + tetracycline + metronidazole).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VOQUEZNA-3

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VOQUEZNA TRIPLE PAK

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of H. Pylori

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 weeks

OTHER CRITERIA
Trial of a generic, guideline recommended, first-line regimen for H. pylori infection such as clarithromycin triple therapy (proton pump inhibitor (PPI) + rifabutin + amoxicillin) or bismuth quadruple therapy (PPI + bismuth subcitrate or subsalicylate + tetracycline + metronidazole).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VORASIDENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VORANIGO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VORICONAZOLE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VORICONAZOLE 200 MG VIAL, VORICONAZOLE 200 MG TABLET, VORICONAZOLE 40 MG/ML SUSP, VORICONAZOLE 50 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months (1 year if immunocompromised)

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VORTIOXETINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TRINTELLIX

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VOSEVI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VOSEVI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Trial with one preferred formulary alternative (i.e. Mavyret or Sofosbuvir/Velpatasvir) where they are 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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VOWST

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VOWST

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterology, or Infectious Disease Specialist.

COVERAGE DURATION
3 days

OTHER CRITERIA
(1) Patient has had one or more recurrence(s) of CDI following an initial episode of CDI, and (2) Patient has completed at least 10 days of one of the following antibiotic therapies (oral vancomycin, Dificid) for rCDI 2 to 4 days prior to initiating Vowst.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VOYDEYA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VOYDEYA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology

COVERAGE DURATION
PENDING CMS APPROVAL

OTHER CRITERIA
COC: (1) Physician attestation that the patient continues to benefit from the medication, (2) Used with a C5 Complement inhibitor, and (3) No concurrent use with a C3 Complement inhibitor or Factor B inhibitor.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VUITY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PILOCARPINE HCL 1.25% EYE DROP

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Optometrist or Ophthalmologist

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VUMERITY

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VYKAT XR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VYKAT XR

EXCLUSION CRITERIA
Age less than 4 years old.

REQUIRED MEDICAL INFORMATION
(1) Member has Prader-Willi Syndrome confirmed by genetic testing, and (2) Member has hyperphagia,.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with Endocrinology, or Genetics

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

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

VYVGART

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VYVGART HYTRULO 1,000MG-10,000

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology

COVERAGE DURATION
1 year

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

WAINUA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
WAINUA 45 MG/0.8 ML AUTOINJECT

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

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

WINREVAIR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
WINREVAIR 45 MG VIAL, WINREVAIR 60 MG VIAL, WINREVAIR (2 PACK)

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology, Pulmonology, Hematology, Immunology, or Allergy

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

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

XDEMVY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
XDEMVY

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
One 10mL bottle per 365 days

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

XELJANZ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TOFACITINIB CITRATE, TOFACITINIB CITRATE ER

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Initial- For Rheumatoid Arthritis (RA): (1) Trial of or contraindication to one DMARD (disease modifying antirheumatic drug). For Ankylosing Spondylitis (AS): (1) Trial or contraindication to an NSAID. COC- All indications: Physician attestation that the patient continues to benefit from the medication. For Initial/COC: No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for the same indication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
PENDING CMS APPROVAL

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

XGEVA-BS

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BILPREVDA, BOMYNTRA

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 B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
Travelers diarrhea: 3 days, Hepatic encephalopathy: 1 year, IBS: 3 months, or SIBO: 14 days.

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
1 year

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

XOLREMDI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
XOLREMDI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Genetic testing that shows confirmed variant of CXCR4 consistent with WHIM syndrome, and (2) Weight.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
(1) Is not on concurrent drug that is highly dependent on CYP2D6 for clearance.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

XROMI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
XROMI

EXCLUSION CRITERIA
Patients age 18 and over.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

YULITHIRA

MEDICATION(S)

YULITHIRA

PENDING CMS APPROVAL

ZALEPLON

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZALEPLON

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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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)

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ZELSUVMI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZELSUVMI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology

COVERAGE DURATION
12 weeks

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZEVTERA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZEVTERA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious disease

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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ZIDESAMTINIB

MEDICATION(S)

JIDEYTRO

PENDING CMS APPROVAL

ZIFTOMENIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
KOMZIFTI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZILBRYSQ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZILBRYSQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

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
YES

PREREQUISITE THERAPY REQUIRED
YES

ZOLPIDEM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
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
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZONGERTINIB

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
HERNEXEOS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology.

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

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
For plaque psoriasis: Medical justification specifying why tazarotene and calcipotriene could not be used. Seborrheic Dermatitis: Medical justification specifying why one topical corticosteroid can not be used.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

ZORYVE-AD

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ZORYVE 0.05% CREAM, 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.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZURZUVAE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZURZUVAE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PENDING CMS APPROVAL

COVERAGE DURATION
2 weeks

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

ZYMFENTRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZYMFENTRA, ZYMFENTRA PEN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PENDING CMS APPROVAL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
PENDING CMS APPROVAL

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES