



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 داروهایی 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

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

ABSSSI 2 WEEK

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DALBAVANCIN HCL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

2 weeks

OTHER CRITERIA

Medical justification specifying that 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

Labs with culture and sensitivity information.

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

Initial- For Rheumatoid Arthritis (RA): (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 Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): (1) Does not have other known causes of interstitial lung disease (e.g. connective tissue disease, drug toxicity, asbestos or beryllium exposure, hypersensitivity pneumonitis). 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. For Systemic Juvenile Idiopathic Arthritis (SJIA): (1) Trial of or contraindication to the following preferred agents: Tyenne. COC: Physician attestation that the patient continues to benefit from the medication.

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

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

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 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) 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 Uveitis: Does not have isolated anterior uveitis. Polyarticular Juvenile Idiopathic Arthritis (PJIA): (1) No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for PJIA. 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

ADEFOVIR

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ADEFOVIR DIPIVOXIL

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

PREFERRED DRUGS: Combination therapy will be approved with documented resistance. SPECIAL POPULATIONS: Criteria will be applied consistent with AASLD guidelines. This includes hepatitis D virus, coinfection with HIV or HCV, concomitant immunosuppressive therapy, concomitant cytotoxic therapy, virologic failure, transplant (liver or non-liver solid organ), pregnancy, or pediatric.

SYMPTOMATIC ACUTE HEPATITIS (HBsAg positive for less than 6 months): antiviral treatment is only indicated in patients with acute liver failure or protracted severe course (defined by total bilirubin greater than 3 mg/dL, direct bilirubin greater than 1.5 mg/dL, INR greater than 1.5, encephalopathy, or ascites). CHRONIC HEPATITIS B (CHB) TREATMENT DURATION: [1] HBeAg-negative at baseline, treat indefinitely. [2] CHB with cirrhosis, treat indefinitely. [3] For patients with HBeAg positive infection

without cirrhosis, discontinue therapy after HBsAg loss or after treatment consolidation (treat persistently normal ALT and undetectable HBV DNA for 12 months or longer after seroconversion to anti-HBe). [4] For continued therapy beyond the recommended duration, medical justification is required documenting the benefit of continued treatment outweighs the risk of discontinuation. CHB TREATMENT INDICATIONS (HBsAg positive for at least 6 months, without cirrhosis): [A] HBeAg positive, ALT at least 2XULN (ULN for ALT is 35 U/L for males and 25 U/L for females), HBV DNA greater than 20,000 IU/mL, treat. [B] HBeAg positive, ALT at least 2XULN, HBV DNA between 2,000-20,000 IU/mL, evaluate ALT. [C] HBeAg positive, ALT above ULN but below 2XULN, HBV DNA above 2,000 IU/mL, evaluate ALT. [D] HBeAg positive, ALT below ULN, HBV DNA above 20,000 IU/mL, do not treat. [E] HBeAg positive, ALT below ULN, HBV DNA between 2,000-20,000 IU/mL, consider treatment discontinuation. [F] HBeAg negative, ALT at least 2XULN, HBV DNA at least 2,000 IU/mL, treat. [F] HBeAg negative, ALT at least 2XULN, HBV DNA below 2,000 IU/mL, evaluate ALT. [G] HBeAg negative, ALT above ULN but below 2XULN, HBV DNA above or below 2,000 IU/mL, evaluate ALT. [H] HBeAg negative, ALT below ULN, HBV DNA above 2,000 IU/mL, monitor. [I] HBeAg negative, ALT below ULN, HBV DNA below 2,000 IU/mL, do not treat. EVALUATE ALT: Rule out other causes of ALT elevation and treat if age is greater than 40 years old OR evidence of liver necroinflammation (A3 or higher) or fibrosis (F2 or higher) is identified via noninvasive testing or biopsy.

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

For new requests: The diagnosis of PAH (pulmonary arterial hypertension) is confirmed by right heart catheterization, the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition, and the medication used for treatment is consistent with its FDA approved functional class. For continuation of therapy: Physician attestation that the patient has experienced an improvement or slowing of disease progression. For initiation of combination therapy with 3 agents: Patient is refractory or poorly responsive to 2-drug combination therapy and the 3 agents must have different mechanisms of action.

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

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

Documented failure with a multidrug background regimen therapy.

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

AMPHOTERICIN B-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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

COVERAGE DURATION

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

OTHER CRITERIA

N/A

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

AVAPRITINIB

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

AYVAKIT

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

AVIB-CEFT

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

AVYCAZ

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 WEEKS

OTHER CRITERIA

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

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

Labs with culture and sensitivity information.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

FDA approved functional class (WHO Group or NYHA class)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For new requests: The diagnosis of PAH (pulmonary arterial hypertension) is confirmed by right heart catheterization, the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition, and the medication used for treatment is consistent with its FDA approved functional class. For continuation of therapy: Physician attestation that the patient has experienced an improvement or slowing of disease progression. For initiation of combination therapy with 3 agents: Patient is refractory or poorly responsive to 2-drug combination therapy and the 3 agents must have different mechanisms of action.

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

BREXPIPIRAZOLE

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

Psychiatry

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

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

Hematology/Oncology.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

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

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

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

Initial- For Non-radiographic axial spondyloarthritis (NR-AXSPA): 1) C-reactive protein levels above the upper limit of normal, or 2) sacroiliitis on MRI. For Plaque psoriasis (PSO): Psoriasis involving greater than or equal to 3% of body surface area or psoriatic lesions affecting the hands, feet, face, scalp, or genital area.

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 two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq, Orencia. For Psoriatic Arthritis (PSA): (1) Trial of or contraindication to two of the following preferred agents: Cosentyx, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Imuldosa/Otulf/Stequeyma/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 Crohns Disease (CD): (1) Trial of or contraindication to one of the following preferred agents: Imuldosa/Otulf/Stequeyma/Yesintek, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Rinvoq, Skyrizi, Tremfya. For PSO: (1) Trial of or contraindication to two of the following preferred agents: Cosentyx, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Imuldosa/Otulf/Stequeyma/Yesintek, Skyrizi, Tremfya, Otezla. For NR-AXSPA: (1) Trial of or

contraindication to an NSAID. For Polyarticular Juvenile Idiopathic Arthritis (PJIA): (1) Trial of or contraindication to two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Rinvoq, Xeljanz IR, Orencia. 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

CINRYZE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

CINRYZE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Cardiology

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

Initial- For Non-radiographic axial spondyloarthritis (NR-AXSPA): 1) C-reactive protein levels above the upper limit of normal, or 2) sacroiliitis on MRI. For Plaque psoriasis (PSO): Psoriasis involving greater than or equal to 3% of body surface area or psoriatic lesions affecting the hands, feet, face, scalp, or genital area.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

Dose cannot exceed 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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

Dose cannot exceed 99mg/kg/day for deferiprone 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

Drug-induced SIADH.

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

Drug-induced SIADH should be treated by withdrawal of the offending drug and fluid restriction.

Medical justification criteria must be provided including why a formulary alternative such as furosemide cannot be used.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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 SYRINGE, DUPIXENT 300 MG/2 ML SYRINGE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Initial- For treatment of atopic dermatitis (AD): Body surface area (BSA) involvement equal to or greater than 10% or affecting crucial body areas such as the hands, feet, face, genitals, or intertriginous areas. For Eosinophilic esophagitis (EoE): Diagnosis confirmed by esophagogastroduodenoscopy (EGD) with biopsy. For Eosinophilic asthma: Blood eosinophil level of 150 to 1,500 cells/mcl within the past 12 months.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: AD, CRSwNP, CSU, EOE, PN- 6 months, Asthma, BP, COPD- 1 year. COC: All indications- 1 year.

OTHER CRITERIA

Initial- For AD (in patients 2 years and older): (1) Trial of or contraindication to one topical (corticosteroid, calcineurin inhibitor, PDE4 inhibitor, or JAK inhibitor), and (2) No concurrent use of other systemic biological/JAK inhibitor for AD. PN: (1) Chronic pruritis (more than 6 weeks), multiple pruriginous lesions, and history or sign of a prolonged scratching behavior. For Asthma: (1) Concurrent therapy with a medium, high-dose or maximally-tolerated dose of an inhaled corticosteroid (ICS) and one other maintenance medication, (2) One asthma exacerbation requiring systemic corticosteroid burst lasting 3 or more days within the past 12 months, or one serious exacerbation requiring hospitalization or ER visit with the past 12 months, or poor symptom control despite current therapy as evidence by at least 3 of the following within the past 4 weeks: daytime asthma symptoms more than

twice per week, any night waking due to asthma, SABA reliever for symptoms more than twice per week, any activity limitations due to asthma, and (3) no concurrent use of Xolair or other Anti-IL5 biologics when used for asthma. For Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP): (1) a 56-day trial of one topical nasal corticosteroid, and (2) No concurrent use with another systemic biologic or targeted small molecule (e.g. JAK inhibitor, PDE-4 inhibitor) for an autoimmune indication. For COPD: (1) Used in combination with a LAMA/LABA/ICS, and (2) No concurrent use with another systemic biologic or targeted small molecules for eosinophilic COPD. For COC- AD: Members condition is stable or showing clinical improvement, and (2) No concurrent use with other systemic biologics or JAK inhibitors for AD. CRSwNP/EOE/PN: Improvement while on therapy. Asthma: (1) no concurrent use of Xolair, or other anti-IL5 biologic for asthma, (2) continued use of ICS and one other maintenance medication, and (3) clinical response as evidence by: (A) reduction in asthma exacerbations from baselines, (B) decrease utilization of rescue medications, (C) increase in percent predicted FEV1 from pretreatment baselines, or (D) reduction in severity or frequency of asthma-related symptoms. COPD: (1) Used in combination with a LAMA/LABA/ICS, (2) No concurrent use with another systemic biologic or targeted small molecules for eosinophilic COPD, and (3) Members condition is stable or showing clinical improvement.

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

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ROLVEDON

EXCLUSION CRITERIA

Neutrophil count higher than 100,000/mm³.

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 months

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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

OTHER CRITERIA

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

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

Unresolved infection caused by *Haemophilus influenzae*, *Neisseria meningitidis*, or *Streptococcus pneumoniae*. Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

For Paroxysmal nocturnal hemoglobinuria: (1) diagnosis was confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-AP) demonstrated by: (1A) At least 5% PNH cells, or (1B) At least 21% GPI-AP polymorphonuclear cells, and (2) Hemoglobin level of less than 10 g/dL. For C3 glomerulopathy or primary immune-complex membranoproliferative glomerulonephritis: (1) diagnosis was confirmed by kidney biopsy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology, or Nephrology

COVERAGE DURATION

1 year

OTHER CRITERIA

Initial: Documentation of vaccine administration for *Haemophilus influenzae*, *Neisseria meningitidis*, and *Streptococcus pneumoniae* ordered, or vaccination status appropriate for patient with complement deficiency. COC: Physician attestation that the patient continues to benefit from the medication.

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

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

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

ENGRIX-B

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ENGRIX-B ADULT, ENGRIX-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/Otulfli/Stequeyma/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/Otulfli/Stequeyma/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

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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

OTHER CRITERIA

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

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

New: Patient must have at least 4 migraine days per month. COC: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

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

For Asthma New Start: Documentation or record of persistent airflow obstruction as indicated by (1A) pre-bronchodilator FEV1 less than 80% predicted (for adults) or (1B) pre-bronchodilator FEV1 less than 90% predicted (for adolescent), and (2) Blood eosinophil at least 150 cells/uL within 4 weeks. For Asthma COC: Baseline blood eosinophil at least 150 cells/uL prior to treatment AND Clinical information documenting that member has experienced a reduction in at least ONE of the following: (1) reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath, (2) decrease in administration of rescue medication, (3) decrease in exacerbation frequency or (4) increase in predicted FEV1 from the pretreatment baseline.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For Asthma New Start: (1) member has had 1 or more asthma exacerbations in the past 12 months requiring corticosteroid treatment and (2) clinical documentation of poor asthma control despite usage of maximal dosages of an inhaled corticosteroid (ICS) or combination ICS with long-acting beta-2 agonist or has documented intolerance or contraindications to ICS or ICS/LABA usage. For EGPA New Start: Patient is currently receiving a systemic corticosteroid. For EGPA COC: Documentation of positive clinical response to therapy (e.g. reduction in the frequency and/or severity of symptoms and exacerbations, reduction in the daily maintenance oral corticosteroid dose).

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

Patient's weight, CBC with differential drawn within the past 2 weeks. (Labs not required for prophylactic therapy)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

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

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

Initial: (1) diagnosis confirmed by biopsy, (2) patient is at high risk of disease progression, defined by meeting both of the following criteria: a) Patient has proteinuria greater than 0.5 g/day or a urine protein-to-creatinine ratio greater than or equal to 1.5 g/g, and b) Patient has received the maximum or maximally tolerated dose of one Angiotensin converting enzyme (ACE) inhibitor (e.g. enalapril, lisinopril, perindopril, ramipril) or Angiotensin receptor blocker (ARB) (e.g. losartan, olmesartan, valsartan) for greater than or equal to 12 weeks prior to starting Filspari. COC: (1) diagnosis has been confirmed by biopsy, and (2) the patient has had a response to therapy (i.e. reduction in proteinuria from baseline).

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

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

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

New: Patient must have at least 4 migraine days per month. COC: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

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

New: Patient must have at least 4 migraine days per month. COC: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

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

GAPIRONE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

EXXUA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 WEEKS

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

1 year

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

HARLIKU

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

HARLIKU

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

New: (1) diagnosis of AKU confirmed by (1A) elevated urinary homogentisic acid (HGA), or (1B) Molecular genetic testing confirming biallelic pathogenic variants in homogentisate 1,2-dioxygenase (HGD) gene, and (2) Baseline slit-lamp exam results.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by a rheumatologist, geneticist, or metabolic disease specialist with experience in AKU.

COVERAGE DURATION

1 year

OTHER CRITERIA

COC:(1) Documentation of positive clinical response to therapy (e.g., decrease in urine HGA), (2) Slit-lamp reexamination, and (3) CBC results (within prior 6 months).

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

New: 6 months. COC: 1 year.

OTHER CRITERIA

N/A

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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Dermatology

COVERAGE DURATION

New: 3 months. COC: 1 year.

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

IBERDOMIDE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ZENBEXUS

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

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

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ICOTYDE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by a dermatology.

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, Humira, Simlandi, Skyrizi, Tremfya, Otezla, Selarsdi, Steqeyma, Yesintek, and (2) No concurrent use with another systemic biologic or targeted small molecule for PSO. COC: Physician attestation that the patient continues to benefit from the medication.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

ILOPERIDONE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

FANAPT

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

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)

ACUTANE 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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

CIDP, PHI: 1 year. Other Dx: 3 months.

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

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

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

Clinical information provided to support the following: (1A) Confirmation of a diagnosis of IPF by ruling out other ILDs via radiologic evidence of lung fibrosis, (1B) Histological or radiographic evidence confirming the diagnosis of IPF, and (1C) Liver function tests, or (2A) a diagnosis of progressive pulmonary fibrosis confirmed by presence of ILD other than IPF with radiologic evidence of lung fibrosis AND (2B) two of the following signs of fibrotic disease progression within the previous 12 months without alternate explanation: absolute decline in forced vital capacity [FVC] 5 percent or greater predicted or absolute decline in diffusing capacity for carbon monoxide [DLCO] 10 percent or greater predicted, worsening respiratory symptoms, progression of radiologic fibrosis (increased extent or severity of reticular changes, lobar volume loss, or traction bronchiectasis/bronchiolectasis, new ground-glass opacities with traction bronchiectasis, or new/worsening honeycombing), OR (2C) a relative decline in FVC of greater than 10 percent or DLCO greater than 15 percent over 8 to 16 months.

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 of 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

New therapy- documentation or record of a diagnosis of ADPKD, labs including LFTs and bilirubin in the past 30 days and presence of at least 2 risk factors associated with rapidly progressing disease such as a total kidney volume (TKV) of 750 mL or more, hypertension, presence of PKD1 gene, onset of ADPKD symptoms before the age of 30, presence of proteinuria as indicated by labs, high urinary sodium excretion as indicated by labs or increased fibroblast growth factor (FGF) 23. COC- Labs including LFTs and bilirubin in the past 90 days.

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

Initial- For RA: (1) Trial of or contraindication to two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq, Oencia. For PJIA: (1) Trial of or contraindication to two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Oencia, 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

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

Initial- For RA: (1) Trial of or contraindication to two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq, Orencia. For Cryopyrin-Associated Periodic Syndromes (CAPS): (1) One of the following: (i) Genetic test for gain-of-function mutations in the NLRP3 gene, or (ii) Has inflammatory markers (i.e. elevated CRP, ESR, serum amyloid A protein (SAA) or S100 proteins), and (2) Two of the following: urticarial-like rash (neutrophilic dermatitis), cold-triggered episodes, sensorineural hearing loss, musculoskeletal symptoms, chronic aseptic meningitis, skeletal abnormalities. For Deficiency of Interleikin-1 Receptor Antagonists (DIRA): (1) One of the following: (i) Genetic test for gain-of-function mutations in the IL1RN gene, or (ii) Has inflammatory markers (i.e. elevated CRP, ESR), and (2) One of the following: pustular psoriasis-like rashes, osteomyelitis, absence of bacterial osteomyelitis, onychomadesis. 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

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

3 MONTHS

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

KYGEVVI

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

KYGEVVI

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Initial: (1) Genetic test confirming pathogenic variant(s) of TK2 gene, (2) symptom onset on or before 12 years of age, (3) baseline transaminase (ALT, AST) and total bilirubin levels obtained prior to treatment initiation, and (4) documentation of member's current weight. COC: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

12 years and older

PRESCRIBER RESTRICTION

Prescribed by a geneticist, neurologist, or metabolic specialist.

COVERAGE DURATION

1 year

OTHER CRITERIA

Requested starting dose does not exceed 260 mg/kg/day and requested maintenance dose does not exceed 800 mg/kg/day.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

LACTATE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

AMMONIUM LACTATE

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

LAMIVUDINE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

LAMIVUDINE 100 MG TABLET, LAMIVUDINE 100 MG TABLET

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

PREFERRED DRUGS: Must have a history of failure, contraindication, or intolerance to Viread (tenofovir) before Vemlidy is approved. Combination therapy will be approved with documented resistance. **SPECIAL POPULATIONS:** Criteria will be applied consistent with AASLD guidelines. This includes hepatitis D virus, coinfection with HIV or HCV, concomitant immunosuppressive therapy, concomitant cytotoxic therapy, virologic failure, transplant (liver or non-liver solid organ), pregnancy, or pediatric. **SYMPTOMATIC ACUTE HEPATITIS (HBsAg positive for less than 6 months):** antiviral treatment is only indicated in patients with acute liver failure or protracted severe course (defined by total bilirubin greater than 3 mg/dL, direct bilirubin greater than 1.5 mg/dL, INR greater than 1.5, encephalopathy, or ascites). **CHRONIC HEPATITIS B (CHB) TREATMENT DURATION:** [1] HBeAg-

negative at baseline, treat indefinitely. [2] CHB with cirrhosis, treat indefinitely. [3] For patients with HBeAg positive infection without cirrhosis, discontinue therapy after HBsAg loss or after treatment consolidation (treat persistently normal ALT and undetectable HBV DNA for 12 months or longer after seroconversion to anti-HBe). [4] For continued therapy beyond the recommended duration, medical justification is required documenting the benefit of continued treatment outweighs the risk of discontinuation. CHB TREATMENT INDICATIONS (HBsAg positive for at least 6 months, without cirrhosis): [A] HBeAg positive, ALT at least 2XULN (ULN for ALT is 35 U/L for males and 25 U/L for females), HBV DNA greater than 20,000 IU/mL, treat. [B] HBeAg positive, ALT at least 2XULN, HBV DNA between 2,000-20,000 IU/mL, evaluate ALT. [C] HBeAg positive, ALT above ULN but below 2XULN, HBV DNA above 2,000 IU/mL, evaluate ALT. [D] HBeAg positive, ALT below ULN, HBV DNA above 20,000 IU/mL, do not treat. [E] HBeAg positive, ALT below ULN, HBV DNA between 2,000-20,000 IU/mL, consider treatment discontinuation. [F] HBeAg negative, ALT at least 2XULN, HBV DNA at least 2,000 IU/mL, treat. [F] HBeAg negative, ALT at least 2XULN, HBV DNA below 2,000 IU/mL, evaluate ALT. [G] HBeAg negative, ALT above ULN but below 2XULN, HBV DNA above or below 2,000 IU/mL, evaluate ALT. [H] HBeAg negative, ALT below ULN, HBV DNA above 2,000 IU/mL, monitor. [I] HBeAg negative, ALT below ULN, HBV DNA below 2,000 IU/mL, do not treat. EVALUATE ALT: Rule out other causes of ALT elevation and treat if age is greater than 40 years old OR evidence of liver necroinflammation (A3 or higher) or fibrosis (F2 or higher) is identified via noninvasive testing or biopsy.

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

(1) Concurrent use with any other amyloid beta-directed antibodies (e.g., Kisunla, Leqembi IV), (2) active uncontrolled bleeding disorder, (3) concurrent use with any anticoagulant or antiplatelet therapy (except for aspirin at 81 mg daily or less), (4) transient ischemic attacks, stroke, or seizures within 1 year, (5) history of immunologic disorder requiring therapy with immunoglobulins, monoclonal antibodies, immunosuppressants, or plasmapheresis, or (6) cognitive impairment or dementia is due to other medical conditions.

REQUIRED MEDICAL INFORMATION

Initial: (1) CDR score of 0.5 or 1.0, CDR Memory Box score of 0.5 or greater and an MMSE score of 22 or greater, (2) baseline MRI prior to treatment (within 1 year) evaluating for pre-existing amyloid-related imaging abnormalities, (3) confirmation of positive amyloid pathology via PET or CSF assessment, and (4) completed 18 months of treatment with Leqembi IV formulation. COC: Physician attestation that the patient has had response to therapy or continues to benefit from the medication.

AGE RESTRICTION

patient must be 50 to 90 years old.

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

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LEQEMBI IQLIK 500 MG DOSE-2 AI

EXCLUSION CRITERIA

(1) Concurrent use with any other amyloid beta-directed antibodies (e.g., Kisunla, Leqembi IV), (2) active uncontrolled bleeding disorder, (3) concurrent use with any anticoagulant or antiplatelet therapy (except for aspirin at 81 mg daily or less), (4) transient ischemic attacks, stroke, or seizures within 1 year, (5) history of immunologic disorder requiring therapy with immunoglobulins, monoclonal antibodies, immunosuppressants, or plasmapheresis, or (6) cognitive impairment or dementia is due to other medical conditions.

REQUIRED MEDICAL INFORMATION

Initial: (1) CDR score of 0.5 or 1.0, CDR Memory Box score of 0.5 or greater and an MMSE score of 22 or greater, (2) baseline MRI prior to treatment (within 1 year) evaluating for pre-existing amyloid-related imaging abnormalities, and (3) confirmation of positive amyloid pathology via PET or CSF assessment. COC: Physician attestation that the patient has had response to therapy or continues to benefit from the medication.

AGE RESTRICTION

patient must be 50 to 90 years old.

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

18 month

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Dermatology

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

LINEZOLID

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LINEZOLID, LINEZOLID-D5W

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 WEEKS

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Dermatology

COVERAGE DURATION

1 year

OTHER CRITERIA

For Alopecia Areata (AA): (1) Trial of or contraindication to preferred agent: Olumiant. Maximum dose of 50mg daily.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

LOARGYS

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LOARGYS

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

Initial: (1) Diagnosis confirmed by one of the following: (a) genetic testing confirming pathogenic variant(s) of ARG1 gene, (b) enzyme assay confirming absence or reduction of arginase activity (i.e., less than 1% of normal) in erythrocytes, or (c) elevated plasma arginine levels above the upper limit of the normal reference range prior to initiation of therapy, (2) used in conjunction with dietary protein restriction, and (3) documentation of member's current weight. COC: Documentation supporting positive clinical response (e.g., decreased plasma arginine levels, reduction in symptoms, and/or improvement from baseline).

AGE RESTRICTION

2 years and older

PRESCRIBER RESTRICTION

Prescribed by a geneticist, neurologist, or metabolic specialist.

COVERAGE DURATION

Initial: 6 months. COC: 1 year.

OTHER CRITERIA

Requested dose does not exceed 0.2 mg/kg once weekly.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

LOFEXIDINE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

LOFEXIDINE HCL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved for 14 days of treatment.

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

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

HCV RNA level within past 6 months

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

MECHLORETHAMINE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

VALCHLOR

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

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

Maximum recommended daily dose.

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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Maximum recommended daily dosage.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Geneticist, endocrinologist or specialist in treatment of Gaucher disease.

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology

COVERAGE DURATION

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NEREUS

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 month

OTHER CRITERIA

(1) Trial of or contraindication to scopolamine transdermal patches and a first-generation antihistamine (e.g. meclizine, promethazine), and (2) record of motion sickness with other nausea-inducing causes ruled out (e.g. chemotherapy, GERD, pregnancy, migraine).

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

NIACIN

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

NIACIN ER

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Pulmonology, 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

Initial- For Asthma: (1) Concurrent therapy with a medium, high-dose or maximally-tolerated dose of an inhaled corticosteroid (ICS) and one other maintenance medication, (2) One asthma exacerbation requiring systemic corticosteroid burst lasting 3 or more days within the past 12 months, or one serious exacerbation requiring hospitalization or ER visit with the past 12 months, or poor symptom control despite current therapy as evidence by at least 3 of the following within the past 4 weeks: daytime asthma symptoms more than twice per week, any night waking due to asthma, SABA reliever for symptoms more than twice per week, any activity limitations due to asthma, and (3) no concurrent use of Xolair, Dupixent, Tezspire, or any other Anti-IL5 biologics when used for asthma. For COPD: (1) blood eosinophils of greater than or equal to 150 cells/mcL at initiation of therapy (within 6 weeks of dosing) or blood eosinophils of greater than or equal to 300 cells/mcL within 12 months prior to initiation of therapy, (2) history of 2 or more moderate exacerbations (resulting in treatment with systemic glucocorticoids, antibiotics, or both), or 1 or more severe exacerbation (requiring hospitalization or an emergency medical care visit), within the past 12 months, and (3A) Member is currently receiving maintenance inhaled triple therapy (i.e., inhaled corticosteroid [ICS], long-acting

muscarinic antagonist [LAMA], and long-acting beta2-agonist [LABA]), or (3B) Member is currently receiving a LAMA and LABA, and has a contraindication to ICS, and (4) Dose does not exceed 100 mg every 4 weeks. For Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP): (1) a 56-day trial of one topical nasal corticosteroid, and (2) no concurrent use with another systemic biologic or targeted small molecules (e.g. JAK inhibitor, PDE-4 inhibitor) for an autoimmune indication. COC: Physician attestation that the patient continues to benefit from the medication.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

NUEDEXTA

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

DEXTROMETHORPHAN HBR-QUINIDINE

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

Initial: 3 months. COC: 1 year.

OTHER CRITERIA

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

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

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

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

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

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

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TRYNGOLZA

EXCLUSION CRITERIA

Member under 18 years of age.

REQUIRED MEDICAL INFORMATION

Initial: (1) confirmation of the diagnosis by genetic testing (biallelic pathogenic variants in FCS-causing genes [such as LPL, GPIHBP1, APOA5, APO2, LMF1, GPD1, CREB3L3]), (2) labs showing fasting triglycerides (TG) level of 880mg/dL or more, and (3) prescriber attestation that patient has received diet counseling.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

The medication is prescribed by or in consultation with Endocrinology, Gastroenterology, or Lipidology.

COVERAGE DURATION

Initial: 6 months, COC: 1 year.

OTHER CRITERIA

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

N/A

OLUMIANT

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

OLUMIANT

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Initial- Rheumatoid Arthritis (RA): Prescribed by on in consultation with Rheumatology. Alopecia Areata (AA): Prescribed by on in consultation with Dermatology.

COVERAGE DURATION

Initial: 6 months. COC: 1 year.

OTHER CRITERIA

Initial- For RA: (1) Trial of or contraindication to two of the following preferred agents: Humira, Simlandi, Xeljanz IR/XR, Rinvoq, Orencia. For AA: (1) Documentation or record of at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT), and (2) Negative Tuberculosis (TB) test result. COC: Physician attestation that the patient continues to benefit from the medication.

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/Otulfli/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/Otulfli/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

(1) Concurrently using any of the following medications not recommended by the manufacturer: 5HT-3 antagonists, including antiemetics (e.g., ondansetron, granisetron, dolasetron, palonosetron) or alosetron. Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION

New: (1) The patient is established on levodopa treatment, and (2) The patient has motor symptoms that are currently uncontrolled (defined as an average off time of at least 3 hours per day).

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

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) 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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology/Oncology

COVERAGE DURATION

Initial: 6 months. COC: 1 year.

OTHER CRITERIA

N/A

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, ENVARUS 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

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

REQUIRED MEDICAL INFORMATION

For Homozygous Familial Hypercholesterolemia (HoFH), confirmation of the diagnosis by LDLR DNA Sequence Analysis, LDLR Deletion/Duplication Analysis (only if the Sequence Analysis is negative), APOB and PCSK9 testing (if both of the above tests are negative but a strong clinical picture exists), or diagnosis by clinical criteria (history of untreated LDL-C greater than 500 mg/dL together with Xanthoma before 10 years of age). For Heterozygous Familial Hypercholesterolemia (HeFH), an adult with a LDL-C level suggestive of a diagnosis of heterozygous familial hypercholesterolemia (i.e. greater than 190 mg/dL for an adults, or greater than 130 mg/dL for pediatrics). For Primary Hyperlipidemia, documented LDL-C must be 70mg/dL or higher while on the maximally tolerated statin therapy (unless contraindicated) or provide a medical justification as to why statin therapy would not be medically appropriate (e.g., statin intolerance).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For all treatable medical conditions, must currently take high-intensity statin. If there has been a previous trial/failure of either atorvastatin or rosuvastatin, then must currently take maximally tolerated dose of any statin or provide a prescriber attestation of statin-intolerance. For cardiovascular risk reduction, LDL-C must be 70mg/dL or higher while on maximal treatment. For continuation of therapy, criteria have been satisfied AND there is confirmation of LDL reduction.

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

HCV RNA level within past 6 months.

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

Patient's weight, CBC with differential drawn within the past 2 weeks. (Labs not required for prophylactic therapy)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

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

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

Dose does not exceed FDA label maximum.

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

Initial: (1) confirmation of the diagnosis by genetic testing (biallelic pathogenic variants in FCS-causing genes [such as LPL, GPIHBP1, APOA5, APO2, LMF1, GPD1, CREB3L3]), (2) labs showing fasting triglycerides (TG) level of 880mg/dL or more, and (3) prescriber attestation that patient has received diet counseling.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

N/A

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

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 WEEKS

OTHER CRITERIA

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

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

Maximum recommended daily dose.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

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

OTHER CRITERIA

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

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

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

Gastroenterology or Infectious Disease

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology

COVERAGE DURATION

New: 24 weeks. COC: 1 year.

OTHER CRITERIA

N/A

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

QUININE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

QUININE SULFATE

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hepatology, 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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Hep C: Per current AASLD/IDSA guidance. Hep B: 16 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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. COC: 1 year.

OTHER CRITERIA

Initial- For Rheumatoid Arthritis (RA): previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug). For Atopic Dermatitis (AD): 1) Atopic dermatitis covering at least 10% of body surface area or affecting the face, head, neck, hands, feet, groin, or intertriginous areas, and 2) history of failure, contraindication, or reason(s) for intolerance to one of the following: topical corticosteroid, topical calcineurin inhibitors, topical PDE4 inhibitors, or topical JAK inhibitor. For Ankylosing Spondylitis (AS)/ NR-AXSPA: 1) trial or contraindication to an NSAID. 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

RIOCIGUAT

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ADEMPAS

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

For new requests: The diagnosis of PAH (pulmonary arterial hypertension) is confirmed by right heart catheterization, the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition, and the medication used for treatment is consistent with its FDA approved functional class. For continuation of therapy: Physician attestation that the patient has experienced an improvement or slowing of disease progression. For initiation of combination therapy with 3 agents: Patient is refractory or poorly responsive to 2-drug combination therapy and the 3 agents must have different mechanisms of action.

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

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

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

Nephrology

COVERAGE DURATION

3 months.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

SAPHNELO

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

SAPHNELO 120 MG/0.8 ML SYRINGE, SAPHNELO PEN

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by rheumatology

COVERAGE DURATION

1 year

OTHER CRITERIA

Medical justification that Benlysta 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

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

Patient's weight, CBC with differential drawn within the past 2 weeks. (Labs not required for prophylactic therapy)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

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

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

SIBEPREN LIMAB

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

VOYXACT

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Nephrology

COVERAGE DURATION

Initial: 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

FDA approved functional class (WHO Group or NYHA class)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For new requests: The diagnosis of PAH (pulmonary arterial hypertension) is confirmed by right heart catheterization, the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition, and the medication used for treatment is consistent with its FDA approved functional class. For continuation of therapy: Physician attestation that the patient has experienced an improvement or slowing of disease progression. For initiation of combination therapy with 3 agents: Patient is refractory or poorly responsive to 2-drug combination therapy and the 3 agents must have different mechanisms of action.

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

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

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/Stequeyma/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

Initial- For Rheumatoid Arthritis (RA): (1) Trial of or contraindication to two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq, Orencia. 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. 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 Ulcerative Colitis (UC): 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

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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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 FLEXPPO 10 MG/1.5, NORDITROPIN FLEXPPO 15 MG/1.5, NORDITROPIN FLEXPPO 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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

COC: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 3% of body surface area or psoriatic lesions affecting the hands, feet, face, scalp, or genital area.

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

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

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/Otulfli/Stequeyma/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/Otulfli/Stequeyma/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

GPP- New: (1) History of GPP defined by presence of sterile, macroscopically visible pustules on non-acral skin, and (2) No concurrent use with another systemic biologic or targeted small molecules (e.g. JAK inhibitor, PDE-4 inhibitor) for an autoimmune indication. COC: (1) Documentation that the member continues to benefit from the medication, and (2) No concurrent use with another systemic biologic or targeted small molecules (e.g. JAK inhibitor, PDE-4 inhibitor) for an autoimmune indication.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

STIRIPENTOL

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

DIACOMIT

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

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

Medical justification that oral metoclopramide 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

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 PACKET, 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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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

For new requests: The diagnosis of PAH (pulmonary arterial hypertension) is confirmed by right heart catheterization, the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition, and the medication used for treatment is consistent with its FDA approved functional class. For continuation of therapy: Physician attestation that the patient has experienced an improvement or slowing of disease progression. For initiation of combination therapy with 3 agents: Patient is refractory or poorly responsive to 2-drug combination therapy and the 3 agents must have different mechanisms of action.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

Hematology/Oncology.

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

Gastroenterology or Infectious Disease

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

Initial- For Non-radiographic axial spondyloarthritis (NR-AXSPA): 1) C-reactive protein levels above the upper limit of normal, or 2) sacroiliitis on MRI. For Plaque psoriasis (PSO): Psoriasis involving greater than or equal to 3% of body surface area or psoriatic lesions affecting the hands, feet, face, scalp, or genital area.

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

(1) Diagnosis of primary IgAN confirmed by biopsy, (2) Member is currently receiving therapy with an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB), and (3) Confirmation of proteinuria as evidenced by equal to or greater than 0.5 g/day or a UPCR equal to equal to or greater than 0.8 g/g.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

PART B PREREQUISITE

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

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

PREFERRED DRUGS: Must have a history of failure, contraindication, or intolerance to Viread (tenofovir) before Vemlidy is approved. Combination therapy will be approved with documented resistance. **SPECIAL POPULATIONS:** Criteria will be applied consistent with AASLD guidelines. This includes hepatitis D virus, coinfection with HIV or HCV, concomitant immunosuppressive therapy, concomitant cytotoxic therapy, virologic failure, transplant (liver or non-liver solid organ), pregnancy, or pediatric. **SYMPTOMATIC ACUTE HEPATITIS (HBsAg positive for less than 6 months):** antiviral treatment is only indicated in patients with acute liver failure or protracted severe course (defined by total bilirubin greater than 3 mg/dL, direct bilirubin greater than 1.5 mg/dL, INR greater than 1.5, encephalopathy, or ascites). **CHRONIC HEPATITIS B (CHB) TREATMENT DURATION:** [1] HBeAg-

negative at baseline, treat indefinitely. [2] CHB with cirrhosis, treat indefinitely. [3] For patients with HBeAg positive infection without cirrhosis, discontinue therapy after HBsAg loss or after treatment consolidation (treat persistently normal ALT and undetectable HBV DNA for 12 months or longer after seroconversion to anti-HBe). [4] For continued therapy beyond the recommended duration, medical justification is required documenting the benefit of continued treatment outweighs the risk of discontinuation. CHB TREATMENT INDICATIONS (HBsAg positive for at least 6 months, without cirrhosis): [A] HBeAg positive, ALT at least 2XULN (ULN for ALT is 35 U/L for males and 25 U/L for females), HBV DNA greater than 20,000 IU/mL, treat. [B] HBeAg positive, ALT at least 2XULN, HBV DNA between 2,000-20,000 IU/mL, evaluate ALT. [C] HBeAg positive, ALT above ULN but below 2XULN, HBV DNA above 2,000 IU/mL, evaluate ALT. [D] HBeAg positive, ALT below ULN, HBV DNA above 20,000 IU/mL, do not treat. [E] HBeAg positive, ALT below ULN, HBV DNA between 2,000-20,000 IU/mL, consider treatment discontinuation. [F] HBeAg negative, ALT at least 2XULN, HBV DNA at least 2,000 IU/mL, treat. [F] HBeAg negative, ALT at least 2XULN, HBV DNA below 2,000 IU/mL, evaluate ALT. [G] HBeAg negative, ALT above ULN but below 2XULN, HBV DNA above or below 2,000 IU/mL, evaluate ALT. [H] HBeAg negative, ALT below ULN, HBV DNA above 2,000 IU/mL, monitor. [I] HBeAg negative, ALT below ULN, HBV DNA below 2,000 IU/mL, do not treat. EVALUATE ALT: Rule out other causes of ALT elevation and treat if age is greater than 40 years old OR evidence of liver necroinflammation (A3 or higher) or fibrosis (F2 or higher) is identified via noninvasive testing or biopsy.

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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Maximum recommended daily dosage.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

TETRABENAZINE

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

TETRABENAZINE

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

TEZEPELUMAB

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

TEZSPIRE 210 MG/1.91 ML PEN

EXCLUSION CRITERIA

Excluded under Part D if meets coverage criteria under Part B. (Vial and syringe will be reviewed under Part B).

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

12 years and older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

CRSwNP- 6 months, Asthma- 1 year. COC: All indications– 1 year.

OTHER CRITERIA

Initial- For Asthma: (1) Concurrent therapy with a high-dose or maximally tolerated dose of an inhaled corticosteroid (ICS) and one other maintenance medication, (2) one asthma exacerbation requiring systemic corticosteroid burst lasting 3 or more days within the past 12 months, or one serious exacerbation requiring hospitalization or ER visit with the past 12 months, or poor symptom control despite current therapy as evidence by at least 3 of the following within the past 4 weeks: daytime asthma symptoms more than twice per week, any night waking due to asthma, SABA reliever for symptoms more than twice per week, any activity limitations due to asthma, and (3) no concurrent use of Xolair, Dupixent, Nucala or any other Anti-IL5 biologics when used for asthma. For Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP): (1) a 56-day trial of one topical nasal corticosteroid, and (2) no concurrent use with another systemic biologic or targeted small molecules (e.g. JAK inhibitor, PDE-4 inhibitor) for an autoimmune indication. For COC: Physician attestation that the patient continues to benefit from the medication.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

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

Labs with culture and sensitivity information.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 WEEKS

OTHER CRITERIA

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

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

Evidence that patient has tried riluzole tablet in the past

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

3 MONTHS

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

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

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

FDA approved functional class (WHO Group or NYHA class)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

For new requests: The diagnosis of PAH (pulmonary arterial hypertension) is confirmed by right heart catheterization, the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition, and the medication used for treatment is consistent with its FDA approved functional class. For continuation of therapy: Physician attestation that the patient has experienced an improvement or slowing of disease progression. For initiation of combination therapy with 3 agents: Patient is refractory or poorly responsive to 2-drug combination therapy and the 3 agents must have different mechanisms of action.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. 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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

Initial: Medical justification specifying that TWO formulary anti-migraine drugs from different classes have been tried and failed are contraindicated, or would not be medically appropriate. Classes include: (1) Analgesics- acetaminophen, aspirin, naproxen, ibuprofen, diclofenac, and (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

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

3 MONTHS

OTHER CRITERIA

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

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

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Nephrology

COVERAGE DURATION

Initial: 9 months. COC: 1 year.

OTHER CRITERIA

N/A

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/Otulf/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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

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

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

HCV RNA level within past 6 months

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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

OTHER CRITERIA

Trial with 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

Initial: (1) Paroxysmal nocturnal hemoglobinuria diagnosis was confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-AP) demonstrated by: 1A) At least 5% PNH cells, or 1B) At least 21% GPI-AP polymorphonuclear cells, (2) Hemoglobin level of less than 10 g/dL, (3) Used with a C5 Complement inhibitor, and (4) No concurrent use with a C3 Complement inhibitor or Factor B inhibitor.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hematology

COVERAGE DURATION

Initial: 4 months. COC: 1 year.

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

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

AGE RESTRICTION

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

Initial- For Myasthenia Gravis (MG): (1) Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy, and (2A) History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.), or (2B) Patient has a history of failure of at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/ plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control. For Chronic inflammatory demyelinating polyneuropathy (CIDP): (1) Diagnosis of CIDP supported by electrodiagnostic studies, and (2A) Member has had an inadequate response or intolerable adverse event to immunoglobulins, corticosteroids, or plasma exchange, or (2B) Member has a documented clinical reason to avoid therapy with immunoglobulins, corticosteroids, or plasma exchange. COC- Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

1 year

OTHER CRITERIA

For MG: Patient is not receiving Vyvgart Hytrulo in combination with another neonatal Fc receptor blocker (e.g., Imaavy, Rystiggo, Vyvgart) or a complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq). For CIDP: Patient is not receiving Vyvgart Hytrulo in combination with other biologic therapies or

immunoglobulin therapy for CIDP.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology, Genetics

COVERAGE DURATION

New: 6 months. COC: 1 year.

OTHER CRITERIA

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

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

Initial: (1) Diagnosis of PAH (pulmonary arterial hypertension) WHO group 1 is confirmed by right heart catheterization and (2) WHO Functional Class II or III and (3) Results of a baseline 6-minute walk distance (6MWD)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Cardiology, Pulmonology, Hematology, Immunology, or Allergy

COVERAGE DURATION

New: 6 months. COC: 1 year.

OTHER CRITERIA

Initial: (1) On background PAH therapy for at least 3 months as evidenced by pharmacy claims or physician supporting statement with at least TWO of the following agents from different drug classes: (A) oral endothelin receptor antagonist (ambrisentan, bosentan or macitentan), (B) oral phosphodiesterase 5 inhibitors (sildenafil or tadalafil), (C) oral cGMP stimulator (riociguat), (D) prostacyclin agonist (epoprostenol, treprostinil, selexipag or iloprost), or (2) On ONE agent the above drug classes and has a contraindication or intolerance to all of the other drug classes. COC: Documentation that the medication has been effective by either (1) improvement in 6MWD from baseline or (2) improvement in WHO-FC group (e.g., patient has moved from WHO-FC group III to WHO-FC group II or WHO-FC group II to WHO-FC group I).

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

One 10mL bottle per 365 days

OTHER CRITERIA

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

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

Initial: 3 months. COC: 1 year.

OTHER CRITERIA

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

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 mediated 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

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

YULITHIRA

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

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

Labs with culture and sensitivity information.

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

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

JIDEYTRO

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

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Neurology

COVERAGE DURATION

1 year

OTHER CRITERIA

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

PART B PREREQUISITE

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

(1) Diagnosis of postpartum depression (PPD) with an onset of depressive symptoms in the third trimester or within 4 weeks postpartum, documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.), and (2) Patient is currently less than 1 year postpartum.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Psychiatry or Obstetrician-Gynecologist (OB/GYN)

COVERAGE DURATION

2 weeks

OTHER CRITERIA

Member will not receive more than one 14-day course per 12 months.

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

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

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 two of the following preferred agents: Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Xeljanz IR/XR, Rinvoq, Orencia. 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. 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 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 Crohns Disease (CD): (1) Trial of or contraindication to two of the following preferred agents (where ages align): Imuldosa/Otulfi/Steqeyma/Yesintek, Adalimumab-aaty/Adalimumab-kfjp/Hadlima, Rinvoq, Skyrizi, Tremfya. 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. 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