

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ACTEMRA**

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**Drugs**

ACTEMRA, ACTEMRA ACTPEN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

**Required Medical Information**

1. Cytokine release syndrome dx
2. Giant cell arteritis dx
3. Systemic Juvenile Idiopathic Arthritis
4. RA or Polyarticular JIA dx: Pt has previous trial on at least TWO of the following:
  - a. Enbrel, b. Humira, c. Renflexis, d. Rinvoq
4. Systemic sclerosis-associated interstitial lung disease (SSc-ILD)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ACTIMMUNE**

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**Drugs**

ACTIMMUNE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Hypersensitivity to Actimmune or E. coli derived products

**Required Medical Information**

1. Dx chronic granulomatous disease OR Dx severe malignant osteopetrosis

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ADEMPAS**

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**Drugs**

ADEMPAS

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. PAH:
  - a. Pt has previous failure on sildenafil or tadalafil
2. CTPH:
  - a. Pt has failed endarterectomy OR
  - b. Pt considered inoperable for pulmonary endarterectomy AND
  - c. Pt has previous trial on full anticoagulation for at least 90 days

**Age Restrictions**

18 years old or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## AIMOVIG

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### Drugs

AIMOVIG

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:
  - a. Pt experiences greater than or equal to 4 migraine days per month,
  - b. Pt has trial on prophylactic therapy on at least TWO of the following:
    - i. Anti-epileptic drug,
    - ii. Beta-blocker,
    - iii. Antidepressant
  - c. If on Botox therapy, patient must continue to have at least 4 migraine days per month
2. Reauth:
  - a. Pt has had a reduction in the number of migraine days per month

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 Months

Reauth: Plan Year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**AIRDUO**

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**Drugs**

BUDESONIDE/FORMOTEROL FUM, FLUTICASONE PROPIONATE/SA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Pt has failed TWO of the following brands: Advair Diskus, Advair HFA, Breo, Symbicort

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**AJOVY**

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**Drugs**

AJOVY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Initial:
  - a. Pt experiences greater than or equal to 4 migraine days per month,
  - b. Pt has trial on prophylactic therapy on at least TWO of the following:
    - i. Anti-epileptic drug,
    - ii. Beta-blocker,
    - iii. Antidepressant
  - c. If on Botox therapy, patient must continue to have at least 4 migraine days per month
2. Reauth:
  - a. Pt has had a reduction in migraine per month

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 6 Months

Reauth: Plan Year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**ALBENZA**

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**Drugs**

ALBENDAZOLE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

N/A

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ALECENSA**

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**Drugs**

ALECENSA, ALUNBRIG

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of NSCLC that is ALK-positive

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**AMPHOB**

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**Drugs**

AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. If using for empiric therapy:
  - a. Patient must be febrile AND neutropenic

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ANDROGENS**

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**Drugs**

TESTOSTERONE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Two separate testosterone levels drawn on different dates where the total testosterone level is below 300 ng/dL,
2. Pt experiences at least ONE of the following:
  - a. malaise, b. fatigue, c. lethargy, d. muscle loss, e. depression, f. decreased libido,

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ANTIBIOTICS**

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**Drugs**

BAXDELA, DALVANCE, NUZYRA, SIVEXTRO, XENLETA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Medication to be dosed based on FDA approved dosing

**Age Restrictions**

N/A

**Prescriber Restrictions**

Infectious disease specialist or after consultation with an infectious disease specialist

**Coverage Duration**

1 month

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ANTIPSYCHOTIC**

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**Drugs**

CAPLYTA, FANAPT, FANAPT TITRATION PACK, LYBALVI, VERSACLOZ, VRAYLAR

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Previous trial on at least ONE of the following: aripiprazole, clozapine, fluoxetine-olanzapine, haloperidol, olanzapine, quetiapine, risperidone, ziprasidone
2. For Major Depressive Disorder (MDD) or Schizophrenia: Previous trial on Rexulti

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## APO B

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### Drugs

JUXTAPID

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Pt has none of the following health conditions or health concerns:

- a. History of significant hepatic disease,
- b. Alcohol abuse,

### Required Medical Information

1. Pt has untreated, fasting LDL cholesterol greater than 500 mg/dL AND triglycerides less than 300 mg/dL,
2. Pt meets a OR b AND c of the following:
  - a. Pt has documented mutations in both alleles of the LDL receptor or of other genes known to affect LDL receptor function,
  - b. Both of pt's parents have a hx of untreated total cholesterol of greater than 250 mg/dL,
  - c. Pt has xanthomas present before age 10,
3. Pt has failed or is currently taking at least ONE of the following:
  - a. Atorvastatin, Rosuvastatin, or Simvastatin
  - b. Has documented intolerance (e.g. rhabdomyolysis) to statin therapy
4. Pt has previous trial of Repatha OR Praluent

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

1. Initial: 6 mo,

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

2. Reauthorization: 12 mo

**Other Criteria**

BvsD Determination



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2023 Prior Authorization Criteria

**ARCALYST**

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**Drugs**

ARCALYST

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Combination use with a TNF-inhibitor

**Required Medical Information**

1. Diagnosis of cryopyrin-associated periodic syndrome
2. Diagnosis of recurrent pericarditis
3. Diagnosis of deficiency of Interleukin-1 Receptor Antagonist (DIRA)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ARIKAYCE**

---

**Drugs**

ARIKAYCE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Arikayce will be used as part of a combination antibacterial drug regimen
2. Initial:
  - a. Pt has positive sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy
2. Reauth:
  - a. Pt has failed to achieve sputum culture conversion by month 6

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 6 months

Reauth: 6 months

**Other Criteria**

N/A

## ATOPIC DERM

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### Drugs

ADBRY, CIBINQO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Used in combination with another biologic (e.g., Dupixent, Xolair, Humira, Entyvio, and Otezla, etc.)

### Required Medical Information

1. Diagnosis of moderate to severe atopic dermatitis (AD)
  - A. Greater than or equal to 10 percent body surface area coverage
  - B. Failure of two of the following:
    - i. Topical corticosteroid (e.g., fluocinonide, clobetasol, etc.)
    - ii. Topical calcineurin inhibitor (eg. tacrolimus ointment 0.1%)
    - iii. Phototherapy
    - iv. Oral immunomodulator (azathioprine, cyclosporine, methotrexate, or mycophenolate)
    - v. Topical PDE-4 (Eucrisa)

### Age Restrictions

18 years and older

### Prescriber Restrictions

N/A

### Coverage Duration

Plan year

### Other Criteria

N/A

Updated 11/27/2023

## AUSTEDO

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### Drugs

AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRAT

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of chorea associated with Huntington's disease
2. Dx of tardive dyskinesia

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**AUVELITY**

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**Drugs**

AUVELITY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of Major Depressive Disorder (MDD)
2. Patient has previous trial of at least two of the following generic antidepressants: bupropion, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, fluvoxamine, mirtazapine, paroxetine, sertraline, venlafaxine

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**AYVAKIT**

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**Drugs**

AYVAKIT

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Diagnosis of:

- a. Unresectable or metastatic GIST that is platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation positive
- b. Advanced Systemic Mastocytosis

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**BALVERSA**

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**Drugs**

BALVERSA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of locally advanced or metastatic urothelial carcinoma
2. Confirmed fibroblast growth factor receptor (FGFR3 or FGFR2) genetic alteration
3. Progression during or following at least one line of platinum-containing chemotherapy within 12 months

**Age Restrictions**

18 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**BANZEL**

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**Drugs**

RUFINAMIDE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has inadequate seizure control despite treatment with at least ONE anti-epileptic drug

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



## BENLYSTA

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### Drugs

BENLYSTA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Use in severe active lupus nephritis or severe active CNS lupus

### Required Medical Information

1. Pt is currently autoantibody positive,
2. Pt has current active disease,
3. Pt has previous treatment with at least TWO of the following:
  - a. Corticosteroids, b. Antimalarials, c. Immunosuppressives,
4. Pt will continue to receive concomitant standard treatment with at least ONE of the following:
  - a. Corticosteroids, b. Antimalarials, c. Immunosuppressives

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**BESREMI**

---

**Drugs**

BESREMI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of Polycythemia Vera
2. Inadequate response or intolerance to hydroxyurea

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 6 months

Reauth: 12 months

**Other Criteria**

N/A

## BOSULIF

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### Drugs

BOSULIF

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Pt is diagnosed with Philadelphia chromosome positive (Ph+) CML
  - a. Pt's CML is newly diagnosed in chronic phase
  - b. Pt's CML is in chronic phase, accelerated phase, or blast phase,
2. For CML in chronic phase, accelerated phase, or blast phase:
  - a. Pt has previous failure or intolerance to imatinib

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**BRAFTOVI**

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**Drugs**

BRAFTOVI, MEKTOVI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of metastatic melanoma with a BRAF V600E or BRAF V600K mutation
  - a. Will be used in combination (encorafenib [Braftovi] and binimetinib [Mektovi])
2. For encorafenib [Braftovi], dx of metastatic colorectal cancer that is with a BRAF V600E mutation
  - b. Will be used in combination with cetuximab (Erbix)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

## BRUKINSA

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### Drugs

BRUKINSA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of
  - a. Mantle cell lymphoma (MCL)
  - b. Marginal zone lymphoma (MZL)
  - c. Waldenstrom macroglobulinemia
2. Patient has received at least one prior therapy for MCL
3. Patient has been previously treated with anti-CD20-based regimen for MZL

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**CABLIVI**

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**Drugs**

CABLIVI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

A. Initial authorization

1. Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)
2. Started inpatient in combination with plasma exchange

B. Reauthorization

1. Signs of persistent underlying disease (e.g., suppressed ADAMTS13 concentrations)
2. Demonstrated a positive response to therapy by a clinically significant increase in platelet count, reduction in neurological symptoms, or improvement in organ-damage markers

**Age Restrictions**

18 years or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

3 months

**Other Criteria**

Max Duration of therapy 58 days

## CABOMETYX

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### Drugs

CABOMETYX

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of hepatocellular carcinoma
  - a. Previous use of sorafenib
2. Dx of advanced renal cell carcinoma
3. Dx of locally advanced or metastatic differentiated thyroid cancer (DTC)
  - a. progression following prior VEGFR-targeted therapy
  - b. patient is radioactive iodine-refractor or ineligible
  - c. patient is at least 12 years of age or older

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## CALQUENCE

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### Drugs

CALQUENCE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of mantle cell lymphoma
  - a. Pt has been treated with at least one prior therapy
2. Dx of chronic lymphocytic leukemia
3. Dx of small lymphocytic lymphoma

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A



## CAMZYOS

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### Drugs

CAMZYOS

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Patient is currently receiving therapy with any of the following: disopyramide, ranolazine, a combination of beta blockers and calcium channel blockers, strong CYP2C19 inducers or inhibitors (rifampin, fluconazole, fluoxetine, etc), strong CYP3A4 inducers or inhibitors (e.g. phenytoin, rifampin, ritonavir, itraconazole, ketoconazole, etc.)

### Required Medical Information

1. Diagnosed with oHCM according to current guidelines as well as all of the following:
  - A. LVOT gradient greater than or equal to 50mmHg at rest or with provocation
  - B. NYHA class II or III
  - C. Documented LVEF greater than or equal to 55%
2. Alternative causes of cardiac hypertrophy have been ruled out (e.g. amyloidosis, Noonan syndrome, Fabry disease, etc.)
3. Failure of both of the following (not required to be concomitantly) at maximally tolerated doses:
  - A. Beta-blocker (e.g. metoprolol, atenolol, propranolol)
  - B. Calcium channel blocker (e.g. verapamil, diltiazem)
4. Reauthorization criteria: Patient has responded positively to therapy as shown in documentation through symptom and/or exercise tolerance improvements

### Age Restrictions

18 years of age or older

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

## CANCIDAS

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### Drugs

CASPOFUNGIN ACETATE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For invasive aspergillosis:
  - a. Pt has failure on at least ONE other systemic antifungal,
2. If using for empiric therapy:
  - a. Patient must be febrile AND neutropenic

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

BvsD determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**CAPRELSA**

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**Drugs**

CAPRELSA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**CARBAGLU**

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**Drugs**

CARGLUMIC ACID, SAPROPTERIN DIHYDROCHLORI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. For carglumic acid: hyperammonemia due to N-acetylglutamate synthase deficiency
2. For sapropterin: hyperphenylalaninemia due to tetra hydrobiopterin- (BH4-) responsive Phenylketonuria

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

6 Months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**CERDELGA**

---

**Drugs**

CERDELGA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt was diagnosed with Type 1 Gaucher disease by a Clinical Biomedical Geneticist,
2. Pt is unable to use intravenous enzyme replacement,
3. The CYP2D6 genotype has been determined

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## CHOLBAM

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### Drugs

CHOLBAM

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:
  - a. Pt has abnormal results from a urinary bile acids analysis by FAB-MS and neurologic exam,
2. Reauth:
  - a. After at least 3 mo of therapy ALT and AST values have been reduced to less than 50 U/L OR baseline reduced by 80%,
  - b. After at least 3 mo of therapy total bilirubin values have been reduced to less than or equal to 1 mg/dl,
  - c. Pt's body weight has increased by 10% or is stable at the greater than 50th percentile OR liver biopsy shows no evidence of cholestasis since initiation of therapy

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 months,

Reauth: 12 months

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**CIMZIA**

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**Drugs**

CIMZIA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

**Required Medical Information**

1. RA, CD, PsO, PsA, or AS dx: Pt has failed on at least TWO of the following:
  - a. Cosentyx, b. Enbrel, c. Entyvio, d. Humira, e. Renflexis, f. Rinvoq, g. Skyrizi, h. Stelara
2. Non-radiographic axial spondyloarthritis dx:
  - a. Pt has failed therapy with Cosentyx or Rinvoq

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



## COMETRIQ

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### Drugs

COMETRIQ

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of
  - a. Progressive, metastatic medullary thyroid cancer (MMTC)
2. Max daily dose of 140 mg/day

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**COPIKTRA**

---

**Drugs**

COPIKTRA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Previous use of 2 prior therapies for indication

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

## COSENTYX

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### Drugs

COSENTYX, COSENTYX SENSOREADY PEN, COSENTYX UNOREADY

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

### Required Medical Information

1. Ankylosing spondylitis dx
2. Non-radiographic axial spondyloarthritis dx
3. Psoriatic arthritis dx:
  - a. Pt has previous failure of at least ONE of the following: i. Methotrexate, ii. Leflunomide, iii. Hydroxychloroquine, iv. Sulfasalazine, v. Injectable Gold, vi. Oral Gold, vii. Azathioprine, viii. Penicillamine, ix. Cycloprine
4. Plaque psoriasis dx:
  - a. Pt has failed therapy with at least ONE of the following: i. methotrexate, ii. cyclosporine, iii. acitretin
5. Enthesitis-Related Arthritis dx

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**CRINONE**

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**Drugs**

CRINONE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

A. Diagnosis of secondary amenorrhea

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**CROMOLYN SOL**

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**Drugs**

CROMOLYN SODIUM

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Diagnosis of mastocytosis

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## CYSTAGON

---

### Drugs

CYSTAGON

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of nephropathic cystinosis
2. Elevated baseline WBC cysteine levels greater than 2 nmol per 1/2 cystine/mg protein
3. CTNS gene mutation
4. Clinical symptoms of an electrolyte imbalance and polyuria

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## CYSTARAN

---

### Drugs

CYSTADROPS, CYSTARAN

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:
  - a. Pt has corneal cysteine accumulation that has been confirmed by slit-lamp photography,
2. Reauth:
  - a. Must meet ONE of the following:
    - i. Pt had a reduction of 1 or more units in the Corneal Cystine Crystal Score (CCCS) after 6 months of treatment with ophthalmic cysteamine (e.g. Cystaran or Cystadrops)
    - ii. Pt has lack of increase of more than one unit in CCCS when baseline CCCS was less than 1

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

6 Months

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**CYSTIC FIBROSIS**

---

**Drugs**

CAYSTON, TOBRAMYCIN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has had at least ONE positive culture for Pseudomonas aeruginosa
2. If request not for generic tobramycin: Previous trial on generic tobramycin

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD determination



SelectHealth Medicare  
2023 Prior Authorization Criteria

**DAURISMO**

---

**Drugs**

DAURISMO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Equal to or greater than 75 years or has comorbidity preventing use of intensive induction chemotherapy.
2. Be given in combination with low-dose cytarabine

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

**DIACOMIT**

---

**Drugs**

DIACOMIT

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of Dravet syndrome
2. Previous use of clobazam and valproic acid
3. To be used in combination with clobazam

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**DOPTELET**

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**Drugs**

DOPTELET

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Platelet count less than 50,000
2. Pt is scheduled for a procedure where there is a bleeding risk
3. Doptelet will be used for 5 days starting 10 to 13 days prior to the procedure and discontinued 5 to 8 days prior to the procedure
4. For chronic immune thrombocytopenia, has the patient had an insufficient response to a previous treatment (e.g. corticosteroid, immune globulin)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## DRONABINOL

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### Drugs

DRONABINOL

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For HIV-associated wasting syndrome OR cancer-associated anorexia dx:
  - a. Pt has previous trial on megestrol,
2. For CINV dx:
  - a. Pt has previous trial on olanzapine

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**DULERA**

---

**Drugs**

DULERA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Pt has tried and failed TWO of the following brands: Advair Diskus, Advair HFA, Breo, Symbicort

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## DUPIXENT

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### Drugs

DUPIXENT

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Not used in combination with another biologic (e.g., Dupixent, Xolair, Humira, Entyvio, and Otezla, etc.)

For EoE:

- A. Less than 12 years of age and/or body weight less than or equal to 40kg
- B. Hyper eosinophilic syndrome (HES)/eosinophilic granulomatosis with polyangitis (Churg-Strauss syndrome)
- C. History of achalasia or esophageal stricture unable to be passed via standard endoscope
- D. Crohn's disease/ulcerative colitis/celiac disease

For PN:

- A. PN secondary to medications (ie. pembrolizumab, paclitaxel, and carboplatin), uncontrolled thyroid disease, immunodeficiency, endoparasitic infection, active infection (except HIV infection) requiring systemic antibiotics, antivirals, antiprotozoals, or antifungals within last two weeks
- B. Dx of pemphigoid nodularis (bullous pemphigoid), actinic prurigo, epidermolysis bullosa, hypertrophic lichen planus, OR neurotic/psychiatric excoriations (dermatotillomania)

### Required Medical Information

1. Diagnosis of moderate to severe atopic dermatitis (AD)

- A. Greater than or equal to 10 percent body surface area coverage
- B. Failure of two of the following:
  - i. Topical corticosteroid (e.g., fluocinonide, clobetasol, etc.)
  - ii. Topical calcineurin inhibitor (eg. tacrolimus ointment 0.1%)
  - iii. Phototherapy
  - iv. Oral immunomodulator (azathioprine, cyclosporine, methotrexate, or mycophenolate)
  - v. Topical PDE-4 (Eucrisa)

2. Diagnosis of moderate to severe asthma with eosinophilic phenotype

- A. Previous use of an Inhaled corticosteroid (ICS) AND one of the following:
  - i. Inhaled corticosteroid/Long-acting beta-agonist (ICS/LABA)

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

- ii. Long-acting muscarinic antagonist (LAMA) (Spiriva) or ICS/LABA/LAMA (Trelegy)
  - iii. Leukotriene receptor antagonist (LTRA)
- B. Peripheral blood eosinophil level greater than 150 cells/mcL
- C. One or more exacerbations requiring the use of oral corticosteroids in the previous 12 months
- 3. Diagnosis of chronic oral corticosteroid dependent asthma
  - A. Chronic oral corticosteroid therapy for at least the last 3 months
  - B. Previous use of an Inhaled corticosteroid (ICS) AND one of the following:
    - i. Inhaled corticosteroid/Long-acting beta-agonist (ICS/LABA)
    - ii. Long-acting muscarinic antagonist (LAMA) (Spiriva) or ICS/LABA/LAMA (Trelegy)
    - iii. Leukotriene receptor antagonist (LTRA)
- 4. Diagnosis of chronic rhinosinusitis with nasal polyps
  - A. Previous use of at least two weeks of systemic corticosteroid therapy
  - B. Failed at least two weeks of intranasal corticosteroid therapy
- 5. Eosinophilic Esophagitis (EoE)
  - A. Documented diagnosis of EoE confirmed by endoscopic biopsy
  - B. Greater than or equal to 15 intraepithelial eos/hpf
  - C. Failure of at least 8 weeks high-dose PPI
  - D. Failure of swallowed topical corticosteroid (i.e.fluticasone, budesonide)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

- 6. Prurigo nodularis (PN)
  - A. Worst-itch numeric rating scale score (WiNRS) greater than or equal to 7
  - B. Minimum of 20 PN lesions

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

C. Failed two weeks medium potency TCS and a topical vitamin D analogue

Reauthorization Criteria:

A. steroid dependent asthma:

i. Reduction in chronic daily corticosteroid therapy and shown improvement in symptoms

B. chronic rhinosinusitis with nasal polyps:

i. Reduction in their nasal polyp size and nasal congestion



## EMGALITY

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### Drugs

EMGALITY

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:
  - a. Pt experiences greater than or equal to 4 migraine days per month,
  - b. Pt has trial on prophylactic therapy on at least TWO of the following:
    - i. Anti-epileptic drug,
    - ii. Beta-blocker,
    - iii. Antidepressant
  - c. If on Botox therapy, patient must continue to have at least 4 migraine days per month
2. Diagnosis of episodic cluster headache
3. Reauth for chronic or episodic migraine:
  - a. Pt has had a reduction in the number of migraine days per month

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 Months

Reauth: Plan Year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ENBREL**

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**Drugs**

ENBREL, ENBREL MINI, ENBREL SURECLICK

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

**Required Medical Information**

1. Ankylosing spondylitis dx
2. Plaque psoriasis dx: Pt has failed at least ONE of the following:
  - a. methotrexate, b. cyclosporine, c. acitretin
3. RA, JIA, PsA, and Pediatric PsA dx: Pt has failed at least three months therapy on at least ONE of the following:
  - a. methotrexate, b. leflunomide, c. hydroxychloroquine, d. sulfasalazine, e. injectable gold, f. oral gold, g. azathioprine, h. penicillamine, i. cyclosporine

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ENDARI**

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**Drugs**

ENDARI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Renal insufficiency,
2. Uncontrolled liver disease

**Required Medical Information**

1. Dx of Sickle Cell Disease (SCD),
2. Tx to prevent acute complications of sickle cell disease,
3. Previous use, concurrent use, or inability to use generic hydroxyurea,
4. Reauthorization: reduction in the number of acute complications (i.e blood transfusions, sickle cell crisis, hospitalizations) of sickle cell disease since initiating therapy

**Age Restrictions**

5 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## ENDOTHELIN ANTAGONISTS

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### Drugs

AMBRISENTAN, BOSENTAN, LETAIRIS, OPSUMIT, TRACLEER

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Exclusion of all secondary causes of pulmonary hypertension
2. Must be dx with PAH with WHO class II, III, or IV
3. For Opsumit, Letairis, & Tracleer: Previous trial of ambrisentan or bosentan

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## ENSPRYNG

---

### Drugs

ENSPRYNG

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Use of another biologic tx for NMOSD

### Required Medical Information

1. Dx of neuromyelitis optica spectrum disorder (NMOSD) with one of the following:
  - A. Idiopathic single or recurrent events of longitudinally extensive myelitis (3 or more vertebral segment spinal cord MRI lesion)
  - B. Optic neuritis, single, recurrent or simultaneous bilateral
2. Positive for anti-aquaporin-4 (AQP4) antibody,
3. Reauthorization:
  - A. Patient is continuing to receive benefit from treatment

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 months

Reauthorization: 12 months

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**EPCLUSA**

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**Drugs**

SOFOSBUVIR/VELPATASVIR

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Chart notes documenting genotype,

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 Weeks

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**EPIDIOLEX**

---

**Drugs**

EPIDIOLEX

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Previous use of two alternative antiepileptic medications and used in combination with another antiepileptic

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**ERIVEDGE**

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**Drugs**

ERIVEDGE, ODOMZO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has recurring lesions after radiation therapy OR radiation therapy is contraindicated or inappropriate,
2. Pt has recurring lesions after surgical excision OR surgery is contraindicated or inappropriate

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ERLEADA**

---

**Drugs**

ERLEADA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Must meet at least ONE of the following:

1. Erleada will be given combination with a gonadotropin-releasing hormone analog
2. Patient has had a bilateral orchiectomy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**ESBRIET**

---

**Drugs**

PIRFENIDONE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx:
  - a. Idiopathic pulmonary fibrosis (IPF)
2. Dx has been confirmed via high-resolution computed tomography scan and/or lung biopsy,
3. Forced Vital Capacity (FVC) greater than 50 percent predicted value
4. Carbon monoxide diffusing capacity (DLCO) greater than 30 percent predicted value
5. Liver function tests (ALT, AST, and bilirubin) completed prior to initiating therapy
6. Reauth:
  - a. A repeat liver function test has been performed after 3 months of therapy has been completed

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 3 mo,

Reauth: 1 year

**Other Criteria**

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ETHACRYNIC ACID**

---

**Drugs**

ETHACRYNIC ACID

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt needs diuresis for any of the following:
  - a. Edema associated with congestive heart failure, b. Edema associated with cirrhosis of the liver, c. Edema associates with renal disease. d. Short-term management of ascites due to malignancy, idiopathic edema, or lymphedema.
2. Pt has previous trial and failure on a loop diuretic or thiazide diuretic

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**EVRYSDI**

---

**Drugs**

EVRYSDI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of spinal muscular atrophy (SMA)
2. Dx of type I, type II, or type III SMA
3. Review of patient case by an independent review committee recommending initial use of treatment
4. For reauthorization, independent review committee reviews case and recommends ongoing use of therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

Pediatric Neurologist or Neurologist

**Coverage Duration**

Initial: 6 months

Reauthorization: 12 months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**EXKIVITY**

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**Drugs**

EXKIVITY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Abnormal QTcF interval, defined as QT interval of greater than or equal to 470ms
2. History of interstitial lung disease, drug-related pneumonitis, or radiation pneumonitis that required steroid treatment
3. Uncontrolled cardiovascular disease

**Required Medical Information**

1. Diagnosis of locally advanced or metastatic NSCLC with EGFR exon 20 insertion mutations as detected by an FDA-approved test
2. Disease has progressed on or after platinum-based chemotherapy

**Age Restrictions**

18 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

## EXTAVIA

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### Drugs

EXTAVIA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Not covered in combination with other treatments for MS
2. Other neuroinflammatory disease (e.g. neuromyelitis optica)

### Required Medical Information

#### I. Initial authorization

- A. Diagnosis of CIS, RRMS, or SPMS
- B. Previous use of ONE preferred:
  1. Avonex, Briumvi, fingolimod (Gilenya), Ocrevus, Plegridy, Tysabri, dimethyl fumarate (Tecfidera), Copaxone (glatiramer/Glatopa), teriflunomide (Aubagio), Vumerity, Zeposia
- C. CBC within previous 6 months
- D. LFT within previous 6 months
- E. Dx of MS supported by 2017 McDonald diagnostic criteria
  1. Two attacks PLUS two lesions on MRI OR two attacks, one lesion, and evidence of dissemination in space on MRI OR one attack, two lesions, and evidence of dissemination in time on MRI OR one attack, one lesion, and evidence of dissemination in space AND time on MRI, OR demonstration of CSF specific oligoclonal bands OR one attack, one lesion, and evidence of dissemination in space on MRI AND demonstration of CSF-specific oligoclonal bands,

#### II. Reauthorization

- A. Patient is stable on therapy

### Age Restrictions

18 years of age or older

### Prescriber Restrictions

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



**FARESTON**

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**Drugs**

TOREMIFENE CITRATE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Pt has congenital or acquired QT prolongation,
2. Pt has uncorrected hypokalemia,
3. Pt has uncorrected hypomagnesemia

**Required Medical Information**

1. Pt has previous trial and failure or contraindication to tamoxifen therapy,
2. Pt has previous trial and failure or contraindication to aromatase inhibitor therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## FASENRA

---

### Drugs

FASENRA, FASENRA PEN

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Not used in combination with another biologic (e.g., Dupixent, Xolair, Humira, Entyvio, and Otezla, etc.)

### Required Medical Information

1. Previous use of an Inhaled corticosteroid (ICS) AND one of the following:
  - A. Inhaled corticosteroid/Long-acting beta-agonist (ICS/LABA)
  - B. Long-acting muscarinic antagonist (LAMA) (Spiriva) or ICS/LABA/LAMA (Trelegy)
  - C. Leukotriene receptor antagonist (LTRA)
2. One or more exacerbations requiring the use of oral corticosteroids in the previous 12 months
3. Peripheral blood eosinophil level greater than 150 cells/mcL

### Age Restrictions

12 years of age or older

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

BvsD Determination

## FENTANYL

---

### Drugs

FENTANYL CITRATE, FENTANYL CITRATE ORAL TRA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Non-cancer pain use

### Required Medical Information

1. Must have documented maintenance therapy with a long-acting opioid,
2. Documented failure with a short-acting opioid for breakthrough pain

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

6 Months

### Other Criteria

Previous trial on generic fentanyl patches

SelectHealth Medicare  
2023 Prior Authorization Criteria

**FILSPARI**

---

**Drugs**

FILSPARI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Currently receiving dialysis or has undergone kidney transplant

**Required Medical Information**

1. Dx of biopsy verified primary immunoglobulin A (IgA) nephropathy
2. Proteinuria defined as a urine protein-to-creatinine ratio (UPCR) of greater than or equal to 1.5g/g
3. Failure of at least a 3-month trial on SGLT2
4. Failure of at least a 3-month trial on one of the following immunosuppressants:
  - A. azathioprine, cyclophosphamide, cyclosporine, hydroxychloroquine, leflunomide, mycophenolate mofetil, rituximab, tacrolimus,

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**FINTEPLA**

---

**Drugs**

FINTEPLA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of Dravet Syndrome or Lennox Gaustaut Syndrome
2. Previous use of two of topiramate, valproic acid, or clobazam

**Age Restrictions**

2 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## FIRAZYR

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### Drugs

ICATIBANT ACETATE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For HAE type I and II and acquired angioedema:
  - a. Dx has been verified by low C1-INH and/or low C1-INH function levels on two separate occasions,
2. For HAE with normal C1-INH:
  - a. Pt has failed a trial with high-dose non-sedating antihistamines such as cetirizine, desloratadine, or levocetirizine for at least 30 days to rule-out idiopathic angioedema

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

1. Initial: 3 mo,
2. Reauth: 1 year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**FIRDAPSE**

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**Drugs**

FIRDAPSE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

I. Initial authorization

- A. P/Q-type voltage-gated calcium channel antibodies OR Repetitive nerve stimulation consistent with LEMS
- C. Screening for cancer related to LEMS
- D. Experiences moderate to severe weakness interfering with function
- E. Documentation of quantitative myasthenia gravis core and subjective global impression score

II. Reauthorization

- A. Improvements in myasthenia gravis core and subjective global impression score
- B. Screened 3-6 months after initial screening for malignancies

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 3 months

Reauthorization: 6 months

**Other Criteria**

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**FOTIVDA**

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**Drugs**

FOTIVDA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of relapsed or refractory advanced renal cell carcinoma (RCC)
2. Previous failure of two systemic therapies

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**GALAFOLD**

---

**Drugs**

GALAFOLD

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of Fabry disease
  - A. amenable galactosidase alpha gene variant

**Age Restrictions**

16 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**GATTEX**

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**Drugs**

GATTEX

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has been dependent on parenteral nutrition or intravenous support for at least 12 months,
2. Pt has required parenteral nutrition at least 3 times per week for at least 6 months,
3. An adult pt has undergone colonoscopy of the entire colon within the past 6 months or a pediatric pt has undergone a colonoscopy of the entire colon in the past 6 months if there has been unexplained blood in the stool

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 6 months,  
Reauth: Plan Year

**Other Criteria**

N/A

## GAVRETO

---

### Drugs

GAVRETO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of non-small cell lung cancer (NSCLC)
  - A. Metastatic NSCLC identified as rearranged during transfection (RET) fusion-positive
2. Dx of thyroid cancer
  - A. Advanced or metastatic RET-mutant medullary thyroid cancer requiring systemic therapy, OR
  - B. Advanced or metastatic RET fusion-positive thyroid cancer refractory radioactive iodine (if appropriate) requiring systemic therapy

### Age Restrictions

12 and older

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**GENERIC ADVAIR**

---

**Drugs**

FLUTICASONE PROPIONATE/SA, WIXELA INHUB

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Patient has tried and failed brand Advair Diskus

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**GILOTRIF**

---

**Drugs**

GILOTRIF

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of metastatic non-small cell lung cancer (NSCLC)
  - a. The tumor has an epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation
2. Dx of metastatic squamous non-small cell lung cancer (NSCLC)
  - a. Progression after platinum-based chemotherapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**GLEOSTINE**

---

**Drugs**

GLEOSTINE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of primary and metastatic brain tumors following appropriate surgical and/or radiotherapeutic procedures
2. Dx of Hodgkin's lymphoma
  - A. Disease has progressed following initial chemotherapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**GLP 1**

---

**Drugs**

OZEMPIC, RYBELSUS, TRULICITY, VICTOZA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Type 1 diabetes mellitus

**Required Medical Information**

1. Dx type 2 diabetes mellitus
2. For Trulicity, Ozempic, and Rybelsus:
  - a. Patient has tried and failed metformin
3. For Victoza:
  - a. Has the member failed TWO of the following: Trulicity, Rybelsus, or Ozempic

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## GROWTH HORMONE

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### Drugs

GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN 10, NUTROPIN AQ NUSPIN 20, NUTROPIN AQ NUSPIN 5, OMNITROPE, SAIZEN, ZOMACTON

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D and Some Medically Accepted Indications

1. All medically accepted indications not otherwise excluded from Part D

### Exclusion Criteria

1. For Ped GHD:
  - Male at bone age of 16 yo, Female at bone age of 14 yo,
2. Fusion of epiphyses
3. Reauth: Growth velocity is less than 2 cm/yr,

### Required Medical Information

N/A

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

1. Ped GHD:
  - Initial: 6 mo,
  - Reauth: 12 mo,
2. HIV wasting: 48 wks LIFETIME,
3. All others: Plan Year



**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**

1. For Genotropin, Humatrope, Norditropin, Nutropin, & Saizen: Patient has tried BOTH Omnitrope and Zomacton
2. Chronic Renal Insufficiency:
  - a. Meet ALL of the following:
    - i. Pt dxed with CRI AND has not yet received renal transplant,
    - ii. Existing metabolic disorders have been corrected,
    - iii. Ht more than 2 SD below the population mean OR less than 3rd percentile,
    - iv. Height velocity less than 4cm/yr or less than 10th percentile of normal for age and gender,
3. Turner Syndrome:
  - a. Meet ALL of the following:
    - i. Dx of TS confirmed by blood karotype or fibroblast studies,
    - ii. Ht of female pt plotted on TS-specific growth curve AND pt is less than 5th percentile of normal growth curve for girls,
4. Prader-Willi Syndrome:
  - a. Meet ALL of the following:
    - i. Dx of PWS confirmed by appropriate genetic testing,
    - ii. Ht more than 2 SD below the pop mean OR less than 3rd percentile,
    - iii. Ht velocity less than 3cm/yr or less than 10th percentile of normal for age and gender,
5. Small for Gestational Age:
  - a. Meet ALL of the following:
    - i. Dx of SGA as defined as one of the following:
      - (1) Birth weight of less than 2,500g at gestational age of greater than 37 weeks,
      - (2) OR birth weight or length less than 3rd percentile for gestational age,
    - ii. Pt has failed to catch up in ht by 2 yo,
6. AIDS-Related Wasting:
  - a. Meet ALL of the following:
    - i. Involuntary weight loss of more than 10% pre-illness body weight or a BMI less than 20,
    - ii. Failure to respond to dronabinol (Marinol) OR megestrol acetate (Megace),
    - iii. Chronic diarrhea (defined as more than 3 loose stools/day for more than 30 days) OR Chronic weakness and documented fever (30 days, intermittent or constant) in the absence of concurrent illness or condition other than HIV infection that would otherwise explain the symptoms.

SelectHealth Medicare  
2023 Prior Authorization Criteria

**HAEGARDA**

---

**Drugs**

HAEGARDA, ORLADEYO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Initial:
  - a. Dx of HAE type I or II has been verified by low C1-INH and/or low C1-INH functional levels on two separate occasions
  - b. Pt has a history of facial, laryngeal, and/or gastrointestinal HAE attacks
2. Reauthorization:
  - a. Pt had a significant decrease in the frequency of attacks per month or had a significant decrease in the severity or duration of attacks

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**HARVONI**

---

**Drugs**

LEDIPASVIR/SOFOSBUVIR

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Chart notes showing genotype

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Maximum 24 weeks

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**HEMADY**

---

**Drugs**

HEMADY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of Multiple Myeloma (MM)
2. Previous use of generic dexamethasone tablets

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## HEPATITIS C

---

### Drugs

PEGASYS

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For Hep B dx:
  - a. Pre-treatment HBV DNA levels are greater than 20,000 IU/ml,
  - b. Must be used as monotherapy
2. Hep C dx

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

48 weeks

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**HETLIOZ**

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**Drugs**

HETLIOZ LQ, TASIMELTEON

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. For Non-24 Hour Sleep-Wake Disorder:
  - a. Pt is totally blind without light perception
2. For Nighttime Sleep Disturbances in Smith-Magenis Syndrome (SMS)
  - a. Diagnosis been confirmed with genetic testing

**Age Restrictions**

N/A

**Prescriber Restrictions**

Sleep specialist or Neurologist

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## HUMIRA

---

### Drugs

HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PEDIATRIC UC S, HUMIRA PEN-PS/UV STARTER

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Combination therapy with another biologic medication, JAK Inhibitor, or Otezla

### Required Medical Information

1. Ankylosing spondylitis dx
2. RA, JIA, PsA dx: Pt has failed at least three months therapy on at least ONE of the following:
  - a. methotrexate, b. leflunomide, c. hydroxychloroquine, d. sulfasalazine, e. injectable gold, f. oral gold, g. azathioprine, h. penicillamine, i. cyclosporine
3. Hidradenitis suppurativa dx:
  - a. Pt has failed therapy or had an inadequate response to a treatment of oral antibiotics
  - b. Pt has lesions present in at least TWO distinct anatomical areas, one of which is Hurley Stage II or III
4. Noninfectious uveitis dx:
  - a. Pt has previous failure on corticosteroids
5. Adult onset of Ulcerative Colitis or Crohn's disease dx
6. Plaque Psoriasis dx: Pt has failed therapy with at least ONE of the following:
  - a. methotrexate, b. cyclosporine, c. acitretin
7. If asking for 20-40 mg WEEKLY or 80 mg every OTHER week:
  - a. Dx of HS, JIA w/ Uveitis, or Pediatric onset UC require no additional justification for dose
  - b. Dx of Adult onset UC/Crohn's if meeting following criteria:
    - i. Increased weekly or every 10 day dosing requests:
      - a. Pt is not in remission or losing response with every 14 day dosing (provider attestation and verified with at least ONE of the following: a. fecal calprotectin level, b. colonoscopy, c. MRI)
      - b. Subtherapeutic drug levels with no or low antibody levels
    - c. Dx of rheumatoid arthritis: Has member tried every other week dosing with insufficient response?

### Age Restrictions

N/A  
Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**HUMULIN U500**

---

**Drugs**

HUMULIN R U-500 (CONCENTR, HUMULIN R U-500 KWIKPEN)

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Requires more than 200 units of insulin per day

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**HYFTOR**

---

**Drugs**

HYFTOR

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of facial angiofibroma associated with tuberous sclerosis
2. Member's facial angiofibroma cause functional impairment or symptoms such as bleeding or pain

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 weeks

No reauthorization

**Other Criteria**

N/A

**IBRANCE**

---

**Drugs**

IBRANCE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Ibrance used as initial therapy:
  - a. Used in combination with an aromatase inhibitor,
2. Ibrance used after endocrine-based therapy:
  - a. Used in combination with fulvestrant,
  - b. If pt is pre- or perimenopausal: Ibrance and fulvestrant used in combination with a luteinizing hormone-releasing hormone agonist

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## ICLUSIG

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### Drugs

ICLUSIG

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Chronic Phase CML dx
  - a. Resistance or intolerance to at least two prior kinase inhibitors.
2. Accelerated or Blast phase CML OR Ph+ ALL
  - a. No other TKI is indicated
3. T315I-positive CML or T315I-positive ALL

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**IDHIFA**

---

**Drugs**

IDHIFA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Cancer has an isocitrate dehydrogenase-2 (IDH2) mutation as detected by a FDA-approved test,
2. Pt has relapsed or is refractory to one or more prior anticancer regimens

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ILUMYA**

---

**Drugs**

ILUMYA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

**Required Medical Information**

1. Pt has previous trial on TWO of:
  - a. Cosentyx, b. Enbrel, c. Humira, d. Renflexis, e. Skyrizi, f. Stelara

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvD Determination

## IMBRUVICA

---

### Drugs

IMBRUVICA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of CLL/SLL
2. Dx of CLL/SLL w/ 17p deletion
3. Dx of Waldenstrom's Macroglobinemia
4. Dx of cGVHD:
  - a. Member has failed at least one prior systemic therapy

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**IMPAVIDO**

---

**Drugs**

IMPAVIDO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of leishmaniasis (visceral, cutaneous, or mucosal) confirmed by parasite in a clinical specimen
2. Previous use of ketoconazole, fluconazole, paromomycin, or amphotericin
3. Weight 30 kg or greater

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

28 days

**Other Criteria**

N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**INBRIJA**

---

**Drugs**

INBRIJA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Asthma, COPD, or other chronic lung disease

**Required Medical Information**

1. Diagnosis of Parkinson's disease
2. Patient is on maximally tolerated doses of carbidopa-levodopa, is intolerant to carbidopa-levodopa, or has contraindication to carbidopa-levodopa
3. Two or more hours of off time per day
4. Previous use of two alternatives (entacapone, selegiline, rasagiline, pramipexole, bromocriptine, ropinirole)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**INCRELEX**

---

**Drugs**

INCRELEX

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Height standard deviation score of less than -3 based on age and gender,
2. Basal IGF-1 standard deviation score of less than -3 based on age and gender,
3. Normal or elevated growth hormone levels,
4. Pt must have open epiphyses,
5. Gh stimulation test of greater than 10 mcg/L.

**Age Restrictions**

2 years old or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**INLYTA**

---

**Drugs**

INLYTA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of renal cell carcinoma
2. For first line treatment in combination with pembrolizumab (Keytruda) or avelumab (Bavencio)
3. Monotherapy as a second line treatment after previous use of one prior systemic therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**INQOVI**

---

**Drugs**

INQOVI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of myelodysplastic syndrome

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**INREBIC**

---

**Drugs**

INREBIC

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Intolerance, failure, or previous use of ruxolitinib

**Required Medical Information**

- A. Diagnosis of intermediate or high-risk primary or secondary myelofibrosis
- B. Platelet count greater than or equal to  $50 \times 10^9/L$

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**IRESSA**

---

**Drugs**

GEFITINIB

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has ONE of the following:
  - a. EGFR exon 19 deletion,
  - b. EGFR exon 21 deletion,
2. Gefitinib is used as first-line therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## ISTURISA

---

### Drugs

ISTURISA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

#### 1. Dx of Cushings Disease

- a. Baseline mean urinary free cortisol (UFC) level at least 1.5x the upper limit of normal measured over three 24 hour measurements (ULN = 50 micrograms/24 hours or 145 nmol/24 hours)
- b. Symptoms of Cushings Disease (e.g diabetes, central obesity, moon face, buffalo hump, osteoporosis, muscle wasting, hypertension, depression, anxiety)
- c. Failure of pituitary surgery or contraindication to pituitary surgery
- d. Intolerance to pasireotide (Signifor)
- g. Exclusion of other causes of Cushings Syndrome (aside from Cushings Disease which is specifically caused by a pituitary adenoma)

#### 2. For reauthorization:

- a. Recent UFC level showing improvement (less than 48 weeks of treatment) or is within normal limits (after 48 weeks of treatment)
- b. Symptom improvement of Cushings Disease

### Age Restrictions

18 years and older

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**IVIG**

---

**Drugs**

BIVIGAM, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PRIVIGEN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

N/A

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD determination

## JADENU

---

### Drugs

DEFERASIROX

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For blood transfusion dx:
  - a. Pt's serum ferritin is greater than 1000 mcg/L,
  - b. Pt has failed subcutaneous deferoxamine through an inability to achieve desired goals of therapy or been intolerant to therapy,
2. For non-transfusion-dependent thalassemia dx:
  - a. Pt's liver iron concentration is at least 5 mg Fe per gram of dry weight,
  - b. Pt's serum ferritin is greater than 300 mcg/L,
  - c. Pt has failed subcutaneous deferoxamine through an inability to achieve desired goals of therapy or been intolerant to therapy

### Age Restrictions

1. For blood transfusion dx: 2 years old and older,
2. For non-transfusion-dependent thalassemia dx: 10 years old and older

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

Part B before Part D step therapy

Updated 11/27/2023

## JAKAFI

---

### Drugs

JAKAFI

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of:
  - a. Intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis
  - b. Polycythemia vera
  - c. Acute Graft-versus-host disease
  - d. Chronic Graft-versus-host disease
2. For myelofibrosis or polycythemia vera, must have at least ONE of the following:
  - a. Pt has enlarged spleen shown by MRI or CT,
  - b. Pt has palpable splenomegaly
3. For myelofibrosis or polycythemia vera, platelet count greater than or equal to  $50 \times 10^9/L$
4. For the treatment of acute graft-versus-host disease patient has previously failed trial of corticosteroids
5. For the treatment of chronic graft-versus-host disease patient has previously failed one or two lines of systemic therapy

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**JAYPIRCA**

---

**Drugs**

JAYPIRCA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of relapsed/refractory MCL
2. Previous treatment with at least two lines of systemic therapy, including a BTK inhibitor

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**JYNARQUE**

---

**Drugs**

JYNARQUE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of autosomal dominant polycystic kidney disease

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**KALYDECO**

---

**Drugs**

KALYDECO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt genotyped by an FDA-cleared CF mutation test,
2. Pt have one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data

**Age Restrictions**

Tablet: 6 years old or older,  
Granules: 1 month old to 5 years old

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## KERENDIA

---

### Drugs

KERENDIA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of Type 2 Diabetes
  - a. Prior treatment with one SGLT-2 inhibitor (Farxiga or Jardiance)
  - b. Contraindication to SGLT2 inhibitor
    - i. eGFR 45ml/min/m<sup>2</sup> or less
    - ii. Urinary Frequency due to BPH, LUTS, bladder spasm
    - iii. Recurrent genital fungal infection or recurrent urinary tract infection

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

12 months

### Other Criteria

N/A



## KEVEYIS

---

### Drugs

KEVEYIS

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Hypersensitivity to dichlorphenamide or other sulfonamides
2. Use in combination with high-dose aspirin
3. Severe pulmonary disease
4. Hepatic insufficiency (e.g Child-Pugh B or C)

### Required Medical Information

1. Dx of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or related variants.
2. Dx confirmed by genetic testing, provocative testing, ectromyography, or muscle biopsy
3. Previous use or contraindication to acetazolamide
4. Reauthorization:
  - a. improvement in baseline symptoms (e.g. number of attacks per week or month, severity of attacks, duration of attacks, short-form 36 assessment, etc.)

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 months

Reauthorization: 12 months

### Other Criteria

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**KEVZARA**

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**Drugs**

KEVZARA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

**Required Medical Information**

1. Dx of Rheumatoid Arthritis: Pt has previous trial on at least TWO of:
  - a. Enbrel, b. Humira, c. Renflexis, d. Rinvoq
2. Dx of Polymyalgia Rheumatica:
  - a. Established on daily dose of 7.5mg or more of prednisone
  - b. History of disease flare with attempted taper of glucocorticoid treatment

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## KINERET

---

### Drugs

KINERET

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

### Required Medical Information

1. Diagnosis of:
  - a. Neonatal-onset multisystem inflammatory disease (NOMID)
  - b. Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
  - c. Rheumatoid Arthritis (RA)
3. For RA: Pt has previous trial on at least TWO of the following:
  - a. Enbrel, b. Humira, c. Renflexis, d. Rinvoq

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**KISQALI**

---

**Drugs**

KISQALI, KISQALI FEMARA 200 DOSE, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Must meet ONE of the following:

- a. Pt will receive an aromatase inhibitor in combination with Kisqali as initial endocrine based therapy for advanced or metastatic disease,
- b. Pt will receive fluevestrant in combination with Kisqali AND pt is postmenopausal or male

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## KORLYM

---

### Drugs

KORLYM

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Pt using long-term corticosteroid

### Required Medical Information

1. Pt has previously failed surgery or chemotherapy to correct Cushing's disease OR is ineligible for surgery,
2. Pt with type II diabetes diagnosis,
3. If pt is female:
  - a. Pt has negative pregnancy test within past 14 days,
  - b. Pt is currently using non-hormonal form of birth control

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 months,

Reauth: Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**KOSELUGO**

---

**Drugs**

KOSELUGO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Patient has symptomatic, inoperable plexiform neurofibromas (PN)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**KYNMOBI**

---

**Drugs**

APOKYN, APOMORPHINE HYDROCHLORIDE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of Parkinson's disease
  - A. Experiencing off episodes
2. Currently taking an oral formulation of carbidopa/levodopa at least 4 times per day or there is documentation of an inability to take an oral formulation of carbidopa/levodopa 4 times per day
3. Previous use of an immediate release or oral disintegrating carbidopa/levodopa as a rescue for off episodes
4. Previous use of at least one of: a. COMT inhibitor (tolcapone, entacapone), b. Dopamine agonist (ropinirole, pramipexole), c. MAO-B inhibitor (selegiline, rasagiline, safinamide)
5. Prescribed in combination with antiemetic therapy (Not a 5HT3)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**LAMPIT**

---

**Drugs**

LAMPIT

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of Chagas disease (T. cruzi)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

3 months

**Other Criteria**

N/A



## LENVIMA

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### Drugs

LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Renal cell carcinoma dx:
  - a. Will be used in combination with everolimus OR pembrolizumab
2. Thyroid cancer dx:
  - a. Tumor is refractory to treatment with radioactive iodine,
  - b. Used as monotherapy
3. Unresectable hepatocellular carcinoma dx:
4. Endometrial carcinoma dx:
  - a. Will be used in combination with pembrolizumab (Keytruda)
  - b. Does not have microsatellite instability-high or mismatch repair deficiency
  - c. Pt has previously been treated with systemic therapy
  - d. Pt is not a candidate for surgery or radiation

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

**LIDODERM**

---

**Drugs**

LIDOCAINE

**Covered Uses**

All Medically Accepted Indications

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of post-herpetic neuralgia
2. Dx of neuropathy due to diabetes mellitus

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**LIVTENCITY**

---

**Drugs**

LIVTENCITY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Pt is on any other CMV antivirals

**Required Medical Information**

1. Pt weighs at least 35 kg or more
2. History of HSCT or SOT
3. Diagnosis of post-transplant CMV infection/disease with CMV DNA of more than 2730 IU/mL in whole blood or more than 910 IU/mL in plasma
4. CMV disease refractory to or intolerant of first line antiviral treatment (e.g., ganciclovir, valganciclovir, foscarnet, or cidofovir)

**Age Restrictions**

12 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

8 weeks

**Other Criteria**

N/A

**LOKELMA**

---

**Drugs**

LOKELMA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Serum potassium level of 5.0 - 6.5 mmol/L on two separate screenings
2. Reauthorization:
  - a. serum potassium of less than 5.5 mmol/L while on treatment

**Age Restrictions**

18 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial 6 months, Reauthorization 12 months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**LONSURF**

---

**Drugs**

LONSURF

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

A. Metastatic colorectal cancer

1. Pt has previous therapy on the following:

a. A fluoropyrimidine, b. Oxaliplatin, c. Irinotecan, d. Bevacizumab,

2. If cancer is KRAS wild type, pt has received previous therapy with anti-EGFR therapy

B. Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**LORBRENA**

---

**Drugs**

LORBRENA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

N/A

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

## LUCEMYRA

---

### Drugs

LUCEMYRA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Use in combination with barbiturates or benzodiazepines

### Required Medical Information

1. Mitigation of opioid withdrawal symptoms
2. Provider submitted documentation that the patient has been counseled on the risks of taking lofexidine with alcohol
3. Patient has failed clonidine as part of this opioid discontinuation attempt

### Age Restrictions

18 years of age or older

### Prescriber Restrictions

N/A

### Coverage Duration

14 Days

### Other Criteria

N/A



## LUMAKRAS

---

### Drugs

KRAZATI, LUMAKRAS

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Previous KRAS G12C-targeted therapy (other than current)
  - a. Krazati and Lumakras have similar mechanism of action and not recommended to switch between agents upon progression

### Required Medical Information

Initial Authorization:

1. Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC)
2. At least one prior systemic therapy
3. Monotherapy

Reauthorization:

1. Documentation of stable or improved disease

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 months

Reauthorization: 12 months

### Other Criteria

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**LUPKYNIS**

---

**Drugs**

LUPKYNIS

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of lupus nephritis
2. eGFR greater than 45 mL/min/1.73m<sup>2</sup>

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## LYNPARZA

---

### Drugs

LYNPARZA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Combination therapy

### Required Medical Information

1. Ovarian cancer, advanced (BRCA-mutated):
  - a. gBRCAm advanced ovarian cancer in patients who have been treated with 3 or more prior lines of chemotherapy OR,
  - b. First-line maintenance therapy for gBRCAm or sBRCAm advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in adult patients with complete or partial response to first-line platinum-based chemotherapy, OR
  - c. First-line maintenance treatment (in combination with bevacizumab) of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in adults who are in complete or partial response to first-line, platinum-based chemotherapy and whose cancer is associated with homologous recombination deficiency (HRD)-positive status,
2. Recurrent ovarian cancer dx:
  - a. Maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in adults who are in complete or partial response to platinum-based chemotherapy.
3. Breast Cancer (BRCA-mutated, HER2-negative) dx:
  - a. For Metastatic Breast Cancer: Pt has previous trial of chemotherapy in neoadjuvant, adjuvant, or metastatic setting
    - i. If HR positive: pt has t/f endocrine therapy or endocrine therapy is inappropriate for pt
  - b. For High Risk Early Breast Cancer: Pt has previous trial of chemotherapy in neoadjuvant, adjuvant, or metastatic setting
4. Pancreatic cancer (BRCA-mutated):
  - a. disease has not progressed on at least 16 weeks of a first-line, platinum-based chemotherapy regimen
5. Prostate cancer (mCRPC):
  - a. Homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer in adults who have progressed following prior enzalutamide or abiraterone treatment

### Age Restrictions

N/A

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**LYTGOBI**

---

**Drugs**

LYTGOBI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of metastatic cholangiocarcinoma
2. Previous treatment for metastatic cholangiocarcinoma with at least 1 line of systemic therapy
3. Fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

## MAVENCLAD

---

### Drugs

MAVENCLAD

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Not covered in combination with other treatments for MS

### Required Medical Information

#### I. Initial authorization

A. Diagnosis of RRMS or SPMS

B. Previous use of ONE preferred:

1. Avonex, Briumvi, Copaxone (glatiramer acetate/Glatopa), Extavia, fingolimod (Gilenya), Ocrevus, Plegridy, Tysabri, (dimethyl fumarate) Tecfidera, teriflunomide (Aubagio), Vumerity, or Zeposia

C. CBC within previous 6 months

D. LFT within previous 6 months

E. Dx of MS supported by 2017 McDonald diagnostic criteria

1. Two attacks PLUS two lesions on MRI OR two attacks, one lesion, and evidence of dissemination in space on MRI OR one attack, two lesions, and evidence of dissemination in time on MRI OR one attack, one lesion, and evidence of dissemination in space AND time on MRI, OR demonstration of CSF specific oligoclonal bands OR one attack, one lesion, and evidence of dissemination in space on MRI AND demonstration of CSF-specific oligoclonal bands,

#### II. Reauthorization

A. CBC in previous 6 months

B. Lymphocyte count at least 800 cells per microliter before initiating the second treatment course

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**MAVYRET**

---

**Drugs**

MAVYRET

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Confirmation of genotype

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

16 Weeks

**Other Criteria**

N/A



## MEKINIST

---

### Drugs

MEKINIST

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Pt is BRAF(V600E or V600K) mutation positive,
2. Monotherapy or in combination with Tafinlar
3. For Mekinist oral solution: Member has inability to swallow tablets

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## MIGRANAL

---

### Drugs

DIHYDROERGOTAMINE MESYLAT

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Pt experiences at least 2 migraines per month,
2. Pt has trial or contraindication to at least TWO of the following:
  - a. Sumatriptan, b. Rizatriptan, c. Zolmitriptan, d. Naratriptan

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**MS**

---

**Drugs**

AVONEX, AVONEX PEN, COPAXONE, PLEGRIDY, TECFIDERA, TECFIDERA STARTER PACK, VUMERITY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Other neuroinflammatory diseases (e.g neuromyelitis optica)

**Required Medical Information**

1. Dx of CIS, RRMS, or active secondary progressive MS
2. Patient's diagnosis of multiple sclerosis is supported by the 2017 McDonald diagnostic criteria (Please select the appropriate diagnostic finding below based on number of attacks, number of lesions, and additional clinical data needed )?
  - a. Two attacks PLUS two lesions on MRI.
  - b. Two attacks, one lesion, and evidence of dissemination in space on MRI.
  - c. One attack, two lesions, and evidence of dissemination in time on MRI
  - d. One attack, one lesion, and evidence of dissemination in space AND time on MRI. OR demonstration of CSF-specific oligoclonal bands.
  - e. One attack, one lesion, and evidence of dissemination in space on MRI AND demonstration of CSF-specific oligoclonal bands.
3. For new starts only, MRI findings been reviewed and interpreted by a radiologist to confirm the diagnosis and findings. Please note, MRI and radiologist interpretation must be submitted.

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**MULPLETA**

---

**Drugs**

MULPLETA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Platelet count less than 50,000
2. Pt is scheduled for a procedure where there is a bleeding risk
3. Mulpleta will be used for 7 days starting 8 to 14 days prior to the procedure and discontinued 2 to 8 days prior to the procedure

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## MYALEPT

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### Drugs

MYALEPT

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Pt has baseline leptin levels of less than 8 ng/mL for males OR less than 12 ng/mL for females,
2. Pt has ONE of the following:
  - a. Diagnosis of diabetes and is being treated with Metformin AND at least one other antidiabetic agent,
  - b. Diagnosis of hypertriglyceridemia and is being treated with at least ONE antihyperlipidemic agent,
3. Reauth:
  - a. Pt has been screened for the presence of anti-metroleptin antibodies,
  - b. If presence of anti-metroleptin antibodies, pt must still be receiving benefit from Myalept therapy,
  - c. Pt shows improvement in hemoglobin A1c OR fasting triglyceride level

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 months,

Reauth: Plan Year

### Other Criteria

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**MYCAPSSA**

---

**Drugs**

MYCAPSSA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of acromegaly
2. Previous use of octreotide or lanreotide (e.g. Sandostatin LAR or Somatuline Depot)
3. One of the following:
  - A. Patient is not a candidate for surgery, radiation, or alternate drug therapy (i.e. bromocriptine, cabergoline, octreotide IR)
  - B. Previous surgical resection of the pituitary gland

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NAFCILLIN**

---

**Drugs**

NAFCILLIN SODIUM

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Tx of bacterial meningitis caused by methicillin-susceptible Staphylococcus aureus OR endocarditis caused by an oxacillin-susceptible staphylococci species OR other staphylococcal infectious disease caused by a penicillinase-producing staphylococci species

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD determination



## NARCOLEPSY

---

### Drugs

WAKIX

### Covered Uses

Some FDA Approved Indications

### Exclusion Criteria

Patients with severe hepatic impairment

### Required Medical Information

1. For narcolepsy with cataplexy (please note Wakix is only covered for the narcolepsy with cataplexy indication)
  - a. Patient has been diagnosed by a board certified sleep, pulmonology, or neurology specialist
  - b. Patient exhibits symptoms of cataplexy
2. Reauth:
  - a. For narcolepsy with cataplexy: i. Decrease in cataplexy episodes

### Age Restrictions

N/A

### Prescriber Restrictions

Board certified in sleep, pulmonology, or neurology

### Coverage Duration

Plan year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NERLYNX**

---

**Drugs**

NERLYNX

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Breast cancer dx:

- a. Tx of early stage HER2-positive breast cancer following adjuvant trastuzumab-based therapy OR
- b. Tx of HER2-positive breast cancer, in combination with capecitabine, in patients who have received 2 or more prior regimens for metastatic disease

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NEULASTA**

---

**Drugs**

FYLNETRA, NEULASTA, ZIEXTENZO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Neutropenia
2. If requesting Neulasta, Ziextenzo, or Fylnetra, pt has trial on BOTH of the following:
  - a. Fulphila, b. Udenyca

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination

**NEXAVAR**

---

**Drugs**

SORAFENIB TOSYLATE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Used as monotherapy,
2. For HCC dx:
  - a. Treatment for unresectable tumor or recurrent disease,
3. For Thyroid carcinoma dx:
  - a. Tumor is refractory to treatment with iodine

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NEXLETOL**

---

**Drugs**

NEXLETOL

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of familial hypercholesterolemia or established atherosclerotic cardiovascular disease
2. Take in combination with maximally tolerated statin or has documented intolerance (e.g. rhabdomyolysis) to statin therapy
3. Previous use of ezetimibe
4. Previous use of PCSK-9 inhibitor (Praluent or Repatha)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NEXLIZET**

---

**Drugs**

NEXLIZET

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of familial hypercholesterolemia or established atherosclerotic cardiovascular disease
2. Take in combination with maximally tolerated statin or has documented intolerance (e.g. rhabdomyolysis) to statin therapy
3. Previous use of ezetimibe
4. Previous use of PCSK-9 inhibitor (Praluent or Repatha)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NICOTROL**

---

**Drugs**

NICOTROL INHALER, NICOTROL NS

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has tried varenicline or bupropion OR has a contraindication to the use of varenicline or bupropion (established seizure disorder, concurrent anorexia or bulimia, concurrent use of MAOIs, etc)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

**NINLARO**

---

**Drugs**

NINLARO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D and Some Medically Accepted Indications  
Autologous Stem Cell Transplant

**Exclusion Criteria**

1. Pt is refractory to lenalidomide or proteasome inhibitor therapy

**Required Medical Information**

1. Multiple Myeloma
  - A. Combination with lenalidomide (Revlimid) and dexamethasone
  - B. Pt has previous trial on at least ONE other therapy
2. Maintenance therapy after Autologous Stem Cell Transplant

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination



**NITROFURAN**

---

**Drugs**

NITROFURANTOIN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Unable to swallow nitrofurantoin capsules

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NORTHERA**

---

**Drugs**

DROXIDOPA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has previous trial on BOTH of the following:
  - a. Midorine, b. Fludrocortisone

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

2 Weeks

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NOURIANZ**

---

**Drugs**

NOURIANZ

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of Parkinson's disease
2. Nourianz will be used in combination with carbidopa/levodopa
3. Previous use of two of the following:
  - a. dopamine agonist (e.g. pramipexole, ropinirole)
  - b. MAO-B inhibitor (e.g. selegiline, rasagiline)
  - c. COMT inhibitor (e.g. entacapone)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**NOXAFIL**

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**Drugs**

NOXAFIL, POSACONAZOLE, POSACONAZOLE DR

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. For aspergillus or candida prophylaxis:
  - a. Pt is at high risk of developing infections secondary to being severely immunocompromised,
2. For oropharyngeal candidiasis:
  - a. Pt has previous failure on BOTH of the following:
    - 1) Itraconazole, 2) Fluconazole

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

6 Months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NPB INSULIN**

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**Drugs**

INSULIN DEGLUDEC, INSULIN DEGLUDEC FLEXTUOC, LEVEMIR, LEVEMIR FLEXPEN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Is the member younger than 6 years of age? (If under 6, no further questions required)
2. Has the patient failed BOTH Lantus & Toujeo or has documented intolerance to Lantus & Toujeo?

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NUBEQA**

---

**Drugs**

NUBEQA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

- A. Diagnosis of non-metastatic castration-resistant prostate cancer
  - i. Given in combination with GnRH analog OR has had bilateral orchiectomy
- B. Diagnosis of metastatic hormone-sensitive prostate cancer (mHSPC)
  - i. Given in combination with docetaxel

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## NUCALA

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### Drugs

NUCALA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Not used in combination with another biologic (e.g., Dupixent, Humira, Entyvio, and Otezla, etc.)

### Required Medical Information

1. For Severe asthma dx:
  - a. One or more exacerbations requiring the use of oral corticosteroids in the previous 12 months
  - b. Peripheral blood eosinophil level is greater than or equal to 150 cells/mcL within the last 6 months OR greater than equal to 300 cell/mcL within last 12 months
  - c. Failure of Dupixent AND Fasenra
2. For HES dx:
  - a. Verified diagnosis of HES for greater than or equal to 6 months without an identifiable non-hematologic secondary cause
  - b. History of at least two HES flares (HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy) within the past 12 months
  - c. Blood eosinophil count of greater than or equal to 1,000 cells/mcL
  - d. Stable HES therapy for 4 weeks prior to treatment (chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy)
3. Dx of Chronic Rhinosinusitis with Nasal Polyps (CRwNP)
  - a. Failure of both Dupixent AND Xolair
  - b. Reauthorization for nasal polyps:
    - i. Reduction in their nasal polyp size and nasal congestion
4. Dx of eosinophilic granulomatosis with polyangiitis (Churg Strauss syndrome)

### Age Restrictions

6 years of age and older

### Prescriber Restrictions

N/A  
Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination



SelectHealth Medicare  
2023 Prior Authorization Criteria

**NUEDEXTA**

---

**Drugs**

NUEDEXTA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has score of 13 or greater on Center for Neurologic Study-Liability Scale (CNS-LS) for pseudobulbar affect (PBA)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

6 Months

**Other Criteria**

N/A

## NUPLAZID

---

### Drugs

NUPLAZID

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:
  - a. Onset of psychosis took place after the diagnosis of Parkinson's disease,
  - b. Pt has previous trial on treatment with clozapine or quetiapine,
2. Reauth:
  - a. Pt experienced a decrease in psychosis related symptoms while on treatment

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 3 months,  
Reauth: 12 months

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NURTEC**

---

**Drugs**

NURTEC

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. For Acute Treatment of Migraines:
  - a. Patient has tried 2 generic triptan medications OR has a contraindication to the use of triptans (e.g. established cardiovascular disease or cerebrovascular disease)
2. For Prophylaxis of Migraines:
  - a. Trial of Ajovy AND
  - b. Trial of one of: Aimovig OR Emgality

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**NYVEPRIA**

---

**Drugs**

NYVEPRIA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Neutropenia
2. Pt has trial on BOTH of the following:
  - a. Fulphila, b. Udenyca

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination

## OCALIVA

---

### Drugs

OCALIVA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

#### 1. Initial:

a. Dx of PBC is confirmed by at least TWO of the following:

i. Elevated mean alkaline phosphatase (ALP) levels of at least 1.5 times the upper limit of normal (ULN) from at least two consecutive readings separated by at least one month (more than 175 U/L for women and 195 U/L for men),

ii. Positive for antimitochondrial antibody (AMA) titer (greater than 1:40 titer on immunofluorescence or M2 positive by enzyme-linked immunoabsorbant assay) or PBC-specific antinuclear antibodies,

iii. Liver biopsy showing histological evidence of PBC (nonsuppurative destructive cholangitis and destruction of interlobular bile ducts),

b. Pt has trial on ursodiol,

c. Ocaliva will be taken in combination with ursodiol,

d. Pt has ALP at least 1.67 times the upper limit of normal (ULN) (At least 197 U/L for females and 207 U/L for males),

e. Pt has a total bilirubin greater than the ULN, but less than 2 times the ULN (value between 1.1 - 2.2 mg/dL for females and 1.5 - 3 mg/dL for males),

#### 2. Reauth:

a. Pt has had improvement in ALP while on Ocalvia

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## OCTREOTIDE

---

### Drugs

OCTREOTIDE ACETATE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For acromegaly:
  - a. Has patient failed at least TWO of the following:
    - i. Surgical resection,
    - ii. Pituitary irradiation,
    - iii. Bromocriptine,
  - b. Pt has elevated levels of growth hormone and IGF-1,
2. For carcinoid:
  - a. Pt is suffering from severe diarrhea and flushing episodes associated with disease,
3. For VIPoma:
  - a. Pt has profuse water diarrhea associated with disease

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

1. For acromegaly: 6 mo,
2. For others: Plan year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**

BvsD determination



**SelectHealth Medicare  
2023 Prior Authorization Criteria**

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**OFEV**

**Drugs**

OFEV

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Pt is receiving anticoagulation therapy

**Required Medical Information**

1. Dx:
  - a. Chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype, idiopathic pulmonary fibrosis (IPF), or scleroderma (systemic sclerosis)-associated interstitial lung disease (SSc-ILD)
2. Dx has been confirmed via high-resolution computed tomography scan and/or lung biopsy,
3. For Ofev, Forced Vital Capacity (FVC) greater than 40 percent predicted value
4. Carbon monoxide diffusing capacity (DLCO) greater than 30 percent predicted value
5. Liver function tests (ALT, AST, and bilirubin) completed prior to initiating therapy
6. Reauth:
  - a. A repeat liver function test has been performed after 3 months of therapy has been completed

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 3 mo,  
Reauth: 1 year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**OJJAARA**

---

**Drugs**

OJJAARA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of intermediate or high-risk myelofibrosis (MF) or secondary MF [post-polycythemia vera (PV) and post-essential thrombocythemia (ET)]
2. Hemoglobin less than 10g/dL
3. Patient has tried and failed or has intolerance to Jakafi

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**OLUMIANT**

---

**Drugs**

OLUMIANT

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

**Required Medical Information**

1. Pt has previous trial on at least TWO of the following:
  - a. Enbrel, b. Humira, c. Renflexis, d. Rinvoq
2. Pt has tried a TNF inhibitor

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ONFI**

---

**Drugs**

SYMPAZAN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has previous trail on at least TWO AED medications

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ONUREG**

---

**Drugs**

ONUREG

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of one of:

A. acute myeloid leukemia (AML) who achieved first complete remission (CR)

B. AML in complete remission with incomplete blood count recovery (CRI) following intensive induction chemotherapy and the member is not able to complete intensive curative therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## ORENCIA

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### Drugs

ORENCIA, ORENCIA CLICKJECT

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

### Required Medical Information

1. For prophylaxis of Acute Graft vs Host disease
  - a. Is the pt undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele mismatched unrelated donor?
  - b. Will Orencia be used in combination with a calcineurin inhibitor and methotrexate?
2. For RA, pJIA, PsA: Pt has previous trial on TWO of the following:
  - a. Cosentyx, b. Enbrel, c. Humira, d. Renflexis, e. Rinvoq, f. Stelara g. Skyrizi

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

BvsD Determination

**ORFADIN**

---

**Drugs**

NITISINONE, NITYR, ORFADIN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Initial:
  - a. Diagnosis of hereditary tyrosinemia type 1 confirmed by biochemical or DNA testing
  - b. Pt had a baseline succinylacetone (SA) level drawn
  - c. Pt had a baseline liver function testing performed
2. Reauthorization:
  - a. There is laboratory documentation of SA suppression on treatment when compared to baseline level

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



## ORGOVYX

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### Drugs

ORGOVYX

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Previous treatment with another GnRH/LHR agonist/antagonist

### Required Medical Information

1. Dx of castrate-sensitive metastatic prostate cancer
2. Dx of metastatic disease has been confirmed by bone scan, ultrasound, CT, MRI, or biopsy
3. Serum PSA is elevated
4. Contraindication or inability to take other GNRH/LHR agonist/antagonist medication due to one of:
  - A. Short term (6 month) use in men at risk of toxicities from standard androgen deprivation therapy (ADT)
  - B. Intermittent ADT in frail patients at risk of ADT toxicities
  - C. Significant underlying cardiac risk factors

### Age Restrictions

18 years of age or older

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ORIAHNN**

---

**Drugs**

MYFEMBREE, ORIAHNN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Heavy menstrual bleeding associated with uterine leiomyomas (fibroids)
2. Premenopausal
3. Previous use of a combination oral contraceptive
4. Previous use of a progestin-only contraceptive

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ORILISSA**

---

**Drugs**

ORILISSA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1) previous use of combination oral contraceptive 2) previous use of progestin-only contraceptive

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months for Orilissa 150 mg

6 months for Orilissa 200 mg

**Other Criteria**

N/A

**ORKAMBI**

---

**Drugs**

ORKAMBI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Initial:
  - a. Pt has cystic fibrosis with the homozygous F508del mutation in the CFTR gene that has been confirmed by an FDA approved test,
2. Reauth:
  - a. Pt has been reassessed since starting therapy,
  - b. Pt's FEV1 has increased since starting therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 3 Months,  
Reauth: 12 Months

**Other Criteria**

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ORSERDU**

---

**Drugs**

ORSERDU

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Postmenopausal female or male with a diagnosis of advanced or metastatic ER+, HER2- breast cancer
2. Confirmation of ESR1-mutated breast cancer
3. The member has experienced disease progression following at least one line of endocrine therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

## OSTEOPOROSIS

---

### Drugs

EVENITY, TERIPARATIDE, TYMLOS

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Duration not to exceed 24 months of cumulative treatment between all anabolic agents (Forteo, Tymlos, Evenity) unless the patient has returned to high risk or remains at high risk for fracture
2. Duration not to exceed 12 months with Evenity
3. For Evenity: Myocardial infarction or stroke in the last 12 months and Male pts

### Required Medical Information

1. For teriparatide and Evenity: Member must fail Tymlos
2. Evenity only: for females only per FDA label
3. Diagnosis of osteoporosis or osteopenia
4. At least one of the following:
  - a. T-score worse than -3.5
  - b. T-score from -2.5 to -3.5 and at least one of the following:
    - i. History of multiple or recent fragility fracture
    - ii. T/f of oral or IV bisphosphonate or Prolia
  - c. T-score from -1.0 to -2.5 and BOTH of the following:
    - i. History of fragility fracture OR FRAX score of greater than 20% for major fracture or greater than 3% for hip fracture
    - ii. T/f of oral or IV bisphosphonate or Prolia

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

Plan year

**Other Criteria**

N/A

## OTEZLA

---

### Drugs

OTEZLA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Combination therapy with another biologic medication or JAK inhibitor

### Required Medical Information

1. Behcet disease dx: Previous trial on at least ONE of the following:
  - a. Humira, b. Renflexis
2. PsO or PsA dx: Previous trial on at least TWO of the following:
  - a. Cosentyx, b. Enbrel, c. Humira, d. Renflexis, e. Skyrizi, f. Stelara g. Rinvoq

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A



**OXBRYTA**

---

**Drugs**

OXBRYTA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Initial Authorization:

- A. Hemoglobin level between 5.5 and 10.5 g/dL
- B. One or more painful acute sickle cell crises within the past 12 months
- C. Is not receiving regular red-cell transfusion therapy
- D. Previously tried, is currently on, or has a contraindication to hydroxyurea

2. Reauthorization

- A. Experienced an increase in hemoglobin level of at least 1 g/dL

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

6 months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**OXERVATE**

---

**Drugs**

OXERVATE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Previous use of Oxervate

**Required Medical Information**

Diagnosis of neurotrophic keratitis

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

2 months

**Other Criteria**

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**PAH**

---

**Drugs**

SILDENAFIL CITRATE, TADALAFIL, TADLIQ

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Initial:

- a. PAPm greater than or equal to 25 mmHG AND PCWP less than or equal to 15 mmHG,
- b. Pt with positive vasoreactivity test:
  - i. Pt has contraindications to or failed maximum tolerated doses of calcium channel blockers,
- c. For Tadiq requests: Inability to swallow tablets

2. Reauth:

- a. Pt has been reassess within the past 6 months

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

- 1. Tadalafil requests: previous trial on sildenafil

SelectHealth Medicare  
2023 Prior Authorization Criteria

**PALYNZIQ**

---

**Drugs**

PALYNZIQ

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. If PKU dx: Pt has trial on Kuvan therapy
2. All dx: Pt has a blood phenylalanine (Phe) concentration of greater than 600 micromol/L

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination

**PANRETIN**

---

**Drugs**

PANRETIN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1.Systemic anti-KS therapy is required (e.g., more than 10 new KS lesions in the prior month, symptomatic lymphedema, symptomatic pulmonary KS, or symptomatic visceral involvement)

**Required Medical Information**

1. Dx of cutaneous lesions in patients with AIDS-related Karposi's Sarcoma.
2. Reauthorization: Patient is stable on therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 6 months

Reauth: 12 months

**Other Criteria**

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**PCSK**

---

**Drugs**

REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Did the patient fail to achieve LDL-C goal after two separate trials of maximally tolerated statins OR one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin) OR has documented intolerance (e.g. rhabdomyolysis) to statin therapy?
2. ONE of the following:
  - A. Dx of HoFH
  - B. Dx of HeFH or primary hyperlipidemia with fasting LDL-C of 190 mg/dL or greater on at least two separate dates at least 3 months apart
    - i. AND LDL-C remains greater than 100 mg/dL despite treatment on medication therapy
  - C. Dx of ASCVD consisting of MI, stroke, TIA, persistent intermittent claudication, coronary intervention revascularization or angina with proven ischemia
    - i. AND LDL-C remains greater than 70 mg/dL despite treatment on medication therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**PEMAZYRE**

---

**Drugs**

PEMAZYRE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Previously treated, unresectable locally advanced or metastatic cholangiocarcinoma
  - A. Fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test
2. Relapsed or refractory myeloid/lymphoid neoplasms
  - i. Fibroblast growth factor receptor 1 (FGFR1) rearrangement as detected by an FDA-approved test

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**PHENOXYBENZAMINE**

---

**Drugs**

METYROSINE, PHENOXYBENZAMINE HYDROCHL

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Phenoxybenzamine will be used for short-term treatment of hypertension prior to surgical removal of a pheochromocytoma
2. For metyrosine, pt has failed phenoxybenzamine

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

3 mo

**Other Criteria**

N/A



## PHOSPHATE BINDER

---

### Drugs

AURYXIA, LANTHANUM CARBONATE, VELPHORO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of chronic kidney disease (CKD) requiring dialysis
2. Hyperphosphatemia (5.5 mg/dL or greater)
3. Previous use of sevelamer
4. Reauthorization
  - A. Patient is benefiting from treatment

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**PIQRAY**

---

**Drugs**

PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Premenopausal female

**Required Medical Information**

- A. Postmenopausal female or male
- B. Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer
- C. PIK3CA-mutation positive
- D. Receiving or previous use of an aromatase inhibitor
- E. Disease progression after endocrine-based regimen
- F. Use in combination with fulvestrant

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## POMALYST

---

### Drugs

POMALYST

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Multiple myeloma dx:
  - a. Pt has tried BOTH of the following: i. Revlimid, ii. Velcade,
  - b. Pt has demonstrated disease progression within 60 days of completion of prior therapy
2. Kaposi sarcoma dx:
  - a. Experienced failure of highly active antiretroviral therapy (HAART) in patient with AIDS
  - b. HIV-negative

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**PREFEST**

---

**Drugs**

PREFEST

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx vasomotor sx associated with menopause OR moderate to severe symptoms of vulvar and vaginal atrophy associated with menopause OR prevention of postmenopausal osteoporosis

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**PRETOMANID**

---

**Drugs**

PRETOMANID

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of tuberculosis
2. Used as part of an appropriate treatment regimen (e.g. bedaquiline and linezolid)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

6 months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**PREVYMIS**

---

**Drugs**

PREVYMIS

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Pt has Child-Pugh class C hepatic impairment

**Required Medical Information**

1. Pt is post allogeneic hematopoietic stem cell transplant within the last 28 days
2. Pt is a CMV-seropositive recipient [R+]
3. Medication will be discontinued on or before 100 days post-transplantation

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

100 days

**Other Criteria**

BvsD Determination

## PRIMAXIN

---

### Drugs

IMIPENEM/CILASTATIN

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Pt has had a positive culture within the past month indicating a MRSA infection

### Required Medical Information

1. For infections of the lower respiratory tract, urinary tract, intra-abdominal, gynecologic, bone and joint, skin and skin structure, polymicrobial infections, or bacterial septicemia:
  - a. Pt has had a positive culture within the past month for ANY of the following:
    - i. Staphylococcus aureus (MSSA),
    - ii. Streptococcus spp.,
    - iii. Escherichia coli,
    - iv. Klebsiella spp.,
    - v. Enterobacter,
    - vi. Pseudomonas aeruginosa,
    - vii. Other resistant gram-negative bacilli,
    - viii. Other anaerobes,
2. Pt must meet ONE of the following:
  - a. Pt has a CrCl greater than or equal to 5 mL/minute/1.73 m<sup>2</sup>,
  - b. Pt will be on hemodialysis within 48 hours of therapy,
3. Pt has failed at least ONE previous antibacterial and/or other antimicrobial therapy

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

1 Month

**Other Criteria**

BvsD determination



## PROMACTA

---

### Drugs

PROMACTA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For ITP dx:
  - a. Previous failure to corticosteroids, immunoglobulins, OR splenectomy,
  - b. Initial: Evidence of bleeding OR platelet count less than 50,000/microL,
  - c. For Reauth: Platelet count less than 400,000/microL,
2. For Hep C with Thrombocytopenia dx:
  - a. Platelet count less than 75,000/microL,
3. For aplastic anemia dx:
  - a. Pt has an insufficient response to immunosuppressive therapy
  - b. In combination with immunosuppressive therapy for severe aplastic anemia

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

6 Months

### Other Criteria

N/A

Updated 11/27/2023

## PROTEINASE INHIBITOR

---

### Drugs

ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. If request for medication other than Prolastin: Trial and failure or intolerance to Prolastin,
2. Pt has serum alpha-1 antitrypsin less than 11 micromoles,
3. Pt has either PiZZ or PiSZ genotype,
4. If the request is for Zemaira, does the patient have the m-malton genotype

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**PURIXAN**

---

**Drugs**

PURIXAN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Used in conjunction with a combination chemotherapy treatment regimen for ALL,
2. Pt has previous failure on mercaptopurine tablets

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**PYRUKYND**

---

**Drugs**

PYRUKYND, PYRUKYND TAPER PACK

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Homozygous R479H mutation or 2 non-missense mutations, without the presence of another missense mutation, in the PKLR gene

**Required Medical Information**

1. Documented pyruvate kinase deficiency (PKD), presence of at least 2 mutant alleles in PKLR gene, of which at least 1 is a missense mutation
2. 6 or more transfusions in the last 12 months
  - A. If 5 or fewer transfusions, Hb concentration less than or equal to 10.0 g/dL

**Age Restrictions**

18 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**QBREXZA**

---

**Drugs**

QBREXZA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of primary focal axillary hyperhidrosis

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**QINLOCK**

---

**Drugs**

QINLOCK

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of advanced GIST
2. Prior treatment with 3 or more kinase inhibitors, including imatinib

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**QULIPTA**

---

**Drugs**

QULIPTA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of Episodic Migraine or Chronic Migraine
2. Trial of:
  - A. Ajoovy AND
  - B. One of: Aimovig OR Emgality

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## RADICAVA

---

### Drugs

RADICAVA ORS STARTER KIT

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of amyotrophic lateral sclerosis (ALS) based on El Escorial revised criteria
  - A. ALS functional Rating Scaled - Revised (ALSFRS-R) assessment has been completed
2. Pt has a score of 2 points or better on each individual item on the ALSFRS-R assessment

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 months

Reauth: Plan year

### Other Criteria

N/A



## RCC

---

### Drugs

EVEROLIMUS

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

For renal angiomyolipoma, requires immediate surgery

### Required Medical Information

1. For RCC dx:
  - a. Previous failure on either sunitinib or Nexavar,
2. For SEGA or TS dx:
  - a. Patient must require therapeutic intervention and not be a candidate for surgical resection
3. Diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) or with well-differentiated, nonfunctional neuroendocrine tumors (NET) of gastrointestinal (GI), or lung origin which are unresectable, locally advanced or metastatic
4. Diagnosed with renal angiomyolipoma with tuberous sclerosis complex with at least one angiomyolipoma greater than or equal to 3cm where there is not an immediate need for surgery
5. Hormone receptor positive HER2-negative breast cancer
  - a. Previous use of one of letrozole or anastrozole
  - b. Use in combination with one of exemastane, tamoxifen, or fulvestrant

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

## RELISTOR

---

### Drugs

RELISTOR

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Pt has advanced illness, OR
2. For OIC in chronic non-cancer pain dx:
  - a. Pt has been on opioid therapy for a month or more,
3. Pt has tried at least TWO of the following:
  - a. Symproic, b. Movantik
4. For Relistor injection: Pt is unable to take oral Relistor

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

BvsD determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**RELYVRIO**

---

**Drugs**

RELYVRIO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of amyotrophic lateral sclerosis (ALS) as defined by the revised El Escorial criteria

**Age Restrictions**

18 years or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## RETEVMO

---

### Drugs

RETEVMO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of:
  - a. Metastatic RET fusion-positive non-small cell lung cancer (NSCLC)
  - b. Advanced or metastatic RET-mutant medullary thyroid cancer (MTC) in patients who require systemic therapy
  - c. Advanced or metastatic RET fusion-positive thyroid cancer in patients who require systemic therapy and refractory to radioactive iodine, if appropriate
2. Identification of a RET gene alteration using next generation sequencing (NGS), polymerase chain reaction (PCR), or fluorescence in situ hybridization (FISH)

### Age Restrictions

12 years of age and older

### Prescriber Restrictions

N/A

### Coverage Duration

6 months initial, 12 months reauthorization

### Other Criteria

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**REVCovi**

---

**Drugs**

REVCovi

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of adenosine deaminase deficiency (ADA) with Severe Combined Immunodeficiency (SCID) phenotype confirmed by one of the following:
  - A. Deficiency of adenosine deaminase (ADA) in plasma, lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus (less than 1% of normal)
  - B. Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates compared to laboratory standard
  - C. Decrease in ATP concentration in erythrocytes
  - D. Molecular genetic confirmation of mutations in both alleles of the ADA1 gene
  - E. Positive screening by T cell receptor excision circles (TRECs)
2. Not a candidate for or has failed bone marrow transplantation (BMT)
3. Platelets greater than 50,000cell/microl
4. Reauthorization
  - A. The patient has experienced improvement in their plasma ADA activity, red blood cell dATP levels, immune function, and/or red blood cell dAXP levels

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

## REVLIMID

---

### Drugs

LENALIDOMIDE, REVLIMID

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For Multiple Myeloma dx:
  - a. Used in combination with dexamethasone,
2. For MCL:
  - a. Pt has previous trial on bortezomib AND pt has trial on at least ONE other previous therapy
3. For transfusion-dependent anemia due to myelodysplastic syndrome
  - a. Low or imediate-1-risk myelodysplastic syndrome (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities
4. For follicular lymphoma and Marginal zone lymphoma (MZL)
  - a. Used in combination with a rituximab product

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

Updated 11/27/2023



SelectHealth Medicare  
2023 Prior Authorization Criteria

**REXULTI**

---

**Drugs**

REXULTI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

N/A

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**REYVOW**

---

**Drugs**

REYVOW

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Patient has tried 2 generic triptan medications OR has a contraindication to the use of triptans (e.g. established cardiovascular disease or cerebrovascular disease)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**REZLIDHIA**

---

**Drugs**

REZLIDHIA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of relapsed or refractory AML
2. Confirmed IDH-1 mutation

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

## REZUROCK

---

### Drugs

REZUROCK

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

Initial Authorization

1. Dx of chronic graft-versus-host disease (chronic GVHD)
  - a. Failure of two previous lines of systemic therapy
2. For BID dosing in the setting of a PPI:
  - a. Member must try a 30-day trial of one of the following alternative GERD treatment modalities:
    - i. antacids
    - ii. H2RA (ranitidine, famotidine, etc)
  - b. Member must have not responded to daily dosing of Rezerock following at least 30 days of therapy

Reauthorization

3. Documentation of stable or improved disease

### Age Restrictions

12 years of age or older

### Prescriber Restrictions

N/A

### Coverage Duration

12 months

### Other Criteria

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**RILUZOLE**

---

**Drugs**

EXSERVAN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of Amyotrophic Lateral Sclerosis (ALS)
2. Pt T/F of riluzole tablets or contraindication to the use of riluzole tablets

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

## RINVOQ

---

### Drugs

RINVOQ

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

### Required Medical Information

1. Diagnosis of moderate to severe active rheumatoid arthritis OR psoriatic arthritis
  - A. Pt has failed at least three months therapy on at least ONE of the following:
    - i. methotrexate, ii. leflunomide, iii. hydroxychloroquine, iv. sulfasalazine, v. injectable gold, vi. oral gold, vii. azathioprine, viii. penicillamine, ix. cyclosporine,
  - B. Pt has tried and failed a TNF inhibitor
2. Diagnosis of atopic dermatitis affecting greater than or equal to 10 percent body surface area coverage
  - A. Failure of two of the following:
    - i. Topical corticosteroid (e.g. fluocinonide, clobetasol, etc)
    - ii. Topical calcineurin inhibitor (tacrolimus ointment, etc)
    - iii. Phototherapy
    - iv. Oral immunomodulator (azathioprine, cyclosporine, methotrexate, mycophenolate, etc)
    - v. Topical PDE-4 (Eucrisa)
3. Diagnosis of Ulcerative Colitis or Crohn's Disease
  - A. Pt has tried and failed a TNF inhibitor
4. Diagnosis of ankylosing spondylitis OR non-radiographic axial spondyloarthritis
  - A. Pt has tried and failed a TNF inhibitor
5. Is prescriber requesting 45mg dose?
  - A. If yes, does the patient have UC or Crohn's dx and will only use 45mg dose for a total of 8 or 12 weeks? (Please note 45mg dose is only approved for UC and Crohn's and will only be approved for a total of 8 or 12 weeks)

### Age Restrictions

12 years of age and older  
Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**ROZLYTREK**

---

**Drugs**

ROZLYTREK

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of non-small cell lung cancer
  - A. Has reactive oxygen species 1 positive
2. Diagnosis of Neurotrophic receptor tyrosine kinase-positive solid tumors
  - A. Tumor is metastatic or surgical resection likely to result in severe morbidity
  - B. Progression following previous treatment or there is not an adequate alternative treatment

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



## RUBRACA

---

### Drugs

RUBRACA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of recurrent ovarian cancer
  - a. Complete or partial response to platinum-based chemotherapy
2. Rubraca will be used as monotherapy
3. Dx of mCRPC that has deleterious BRCA mutation
  - a. Previous treatment with androgen receptor-directed therapy and a taxane-based chemotherapy

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## RYDAPT

---

### Drugs

RYDAPT

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Used for post-consolidation therapy (maintenance) for dx of AML

### Required Medical Information

1. For AML dx:

a. Cancer is FLT3 mutation positive

2. Dx of systemic mastocytosis

a. Systemic mastocytosis is identified as aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL)

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## SABRIL

---

### Drugs

VIGABATRIN, VIGADRONE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For solution:

a. Must be used as monotherapy for infantile spasms,

2. For tablets:

a. Must be used as adjunctive therapy,

b. Must have tried at least TWO of the following:

i. Banzel, ii. Carbamazepine, iii. Celontin, iv. Depakene, v. Depakote, vi. Dilantin, vii. Divalproex, viii. Eptol, ix. Equetro, x. Ethosuximide, xi. Felbamate, xii. Gabitril, xiii. Keppra, xiv. Lamictal, xv. Lamotrigine, xvi. Levetiracetam, xvii. Lyrica, xviii. Mysoline, xix. Oxcarbazepine, xx. Peganone, xxi. Phenytoin, xxii. Potiga, xxiii. Stavzor, xxiv. Tegretol, xxv. Topamax, xxvi. Topiramate, xxvii. Trileptal, xxviii. Valproic Acid, xxix. Vimpat, xxx. Zonegran, xxxi. Zonisamide

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

1. Periodic vision testing

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**SCEMBLIX**

---

**Drugs**

SCEMBLIX

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML)
2. Trial and failure of at least 2 TKIs
3. For T315I mutation: Documentation of testing for mutation
  - a. Must try and fail ponatinib

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

## SIGNIFOR

---

### Drugs

SIGNIFOR

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:

- a. Pt is NOT a candidate for pituitary surgery,
- b. If pt previously had pituitary surgery: Pt continues to have 24-hour urinary free cortisol levels of:
  - i. 90 micrograms or greater if male,
  - ii. 67 micrograms or greater if female

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 3 mo,

Reauth: Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**SIRTURO**

---

**Drugs**

SIRTURO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has previous failure on at least TWO of the following:

a. Ethambutol, b. Streptomycin, c. Pyrazinamide, d. Amikacin/kanamycin, e. Cycloserine/terizidone, f. Ethionamide, g. Capreomycin, h. Levofloxacin, i. Moxifloxacin, j. Ofloxacin

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

6 Months

**Other Criteria**

N/A

## SITAVIG

---

### Drugs

SITAVIG

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of recurrent herpes labialis
2. Patient is immunocompetent
3. Previous treatment with two generic oral antiviral therapies (acyclovir, famciclovir, valacyclovir)

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## SKYRIZI

---

### Drugs

SKYRIZI, SKYRIZI PEN

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

### Required Medical Information

1. Plaque psoriasis dx
  - A. Pt has previous failure with at least ONE of the following:
    - i. Methotrexate, ii. Cyclosporine, iii. Acitretin
2. Psoriatic arthritis dx
  - A. Pt has previous failure with at least ONE of the following:
    - i. methotrexate ii. leflunomide iii. hydroxychloroquine iv. sulfasalazine v. injectable gold vi. oral gold vii. azathioprine viii. cyclosporine
3. Crohn's disease dx

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A



## SOMAVERT

---

### Drugs

SOMAVERT

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Pt has had surgical resection of the pituitary gland OR is not a candidate for surgery/radiation therapy,
2. Patient has tried at least ONE of the following:
  - a. Bromocriptine, b. Cabergoline, c. Octreotide acetate
3. Patient has tried sandostatin LAR or somatuline depot

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**SPRYCEL**

---

**Drugs**

SPRYCEL

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of CML or ALL

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**STELARA**

---

**Drugs**

STELARA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

**Required Medical Information**

1. Crohn's disease dx
2. Ulcerative Colitis dx
3. Plaque Psoriasis dx: Pt has previous failure with at least ONE of the following:
  - a. methotrexate, b. cyclosporine, c. acitretin
4. Psoriatic arthritis dx: Pt has previous failure with at least ONE of the following:
  - a. methotrexate, b. leflunomide, c. hydroxychloroquine, d. sulfasalazine, e. injectable gold, f. oral gold, g. azathioprine, h. D-penicillamine, i. cyclosporine

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**STIVARGA**

---

**Drugs**

STIVARGA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx metastatic colorectal cancer,
2. Dx gastrointestinal stromal tumor,
3. Dx hepatocellular carcinoma

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**SUCRAID**

---

**Drugs**

SUCRAID

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx is confirmed by a Small Bowel Biopsy Disaccharidase Measurement demonstrating 2 SD or more below mean for sucrase activity with or without isomaltase activity

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## SUTENT

---

### Drugs

SUNITINIB MALATE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Sutent used as combination therapy with other chemotherapies

### Required Medical Information

1. For GIST dx:
  - a. Disease progression or intolerance to imatinib,
2. For pNET dx:
  - a. Tumor is unresectable locally advanced or metastatic

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## **SYMDEKO**

---

### **Drugs**

SYMDEKO

### **Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

### **Exclusion Criteria**

N/A

### **Required Medical Information**

1. Initial:
  - a. Pt has been genotyped by a FDA-approved CF mutation test and the mutation is responsive to Symdeko
  - b. If pt has been previously colonized with rapid decline in pulmonary function, then pt must have had 2 negative respiratory cultures within the past 12 months
2. Reauthorization:
  - a. Pt has been reassessed
  - b. Pt's FEV1 has increased since initiation of Symdeko

### **Age Restrictions**

6 yo and older

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Plan Year

### **Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**SYNAREL**

---

**Drugs**

SYNAREL

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

Pt has previous trial on leuprolide acetate

**Age Restrictions**

1. For CPP: Treatment initiated at or before 8 years of age in girls and 9 years of age in boys
2. For Endometriosis: 18 years old or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

6 Months

**Other Criteria**

N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**SYNRIBO**

---

**Drugs**

SYNRIBO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has resistance and/or intolerance to TWO or more of the following:
  - a. imatinib, b. Sprycel, c. Tassigna, d. Bosulif

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**SYPRINE**

---

**Drugs**

TRIENTINE HYDROCHLORIDE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has failure on penicillamine,

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**TABRECTA**

---

**Drugs**

TABRECTA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of metastatic non-small cell lung cancer (NSCLC)
2. Tumor mutation leading to mesenchymal-epithelial transition (MET) exon 14 skipping

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## TAFINLAR

---

### Drugs

TAFINLAR

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Previous use of Tafinlar, Mekinist, Keytruda, or Opdivo

### Required Medical Information

1. For Melanoma dx: Pt is BRAF (V600E or V600K) mutation positive
2. For NSCLC dx: Pt is BRAF V600E positive
3. For Locally Advanced or Metastatic Anaplastic Thyroid Cancer dx: Pt is BRAF V600E positive with no satisfactory locoregional treatment options
4. For Unresectable or Metastatic Solid Tumors dx: Pt is BRAF V600E positive and has progressed following prior treatment and have no satisfactory alternative treatment options
5. For Tafinlar tablets for oral suspension: Member has inability to swallow capsules

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**TAGRISSO**

---

**Drugs**

TAGRISSO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt is positive for EGFR T790M mutation,
  - a. Pt has previous therapy after EGFR TKI therapy
2. Epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## TAKHZYRO

---

### Drugs

TAKHZYRO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:
  - a. Dx of HAE type I or II has been verified by low C1-INH and/or low C1-INH functional levels on two separate occasions
  - b. Pt has a history of facial, laryngeal, and/or gastrointestinal HAE attacks
2. Reauthorization:
  - a. Pt had a significant decrease in the frequency of attacks per month or had a significant decrease in the severity or duration of attacks

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**TALZENNA**

---

**Drugs**

TALZENNA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of HRR Gene-mutated mCRPC, in combination with enzalutamide (Xtandi)
2. Dx of deleterious or suspected deleterious germline BRCA, HER2-negative locally advanced or metastatic breast cancer

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

**TARCEVA**

---

**Drugs**

ERLOTINIB HYDROCHLORIDE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. For NSCLC dx:
  - a. Pt with EGFR mutation,
  - b. Erlotinib is not used in combination with platinum-based chemotherapy,
2. For pancreatic cancer dx:
  - a. Combination with gemcitabine

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



## TARGRETIN

---

### Drugs

BEXAROTENE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. If female: Pt planning to become pregnant

### Required Medical Information

1. Capsules:

a. Pt has previous failure on at least ONE of the following:

i. Antineoplastic chemotherapy, ii. Interferon alfa and gamma, iii. Interleuking-12, iv. Interleukin-2,

2. Gel:

a. Pt has previous failure on at least ONE of the following:

i. PUVA, ii. UVB, iii. EVT, iv. Photophoresis, v. Systemic cytotoxic chemotherapy, vi. Topical nitrogen mustard, vii. Topical carmustine

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## TASIGNA

---

### Drugs

TASIGNA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

For Ph+ CML Dx: Pts who have BCR-ABL1 mutations T315I, Y253H, E255K/V, F359V/C/I, or G250E

### Required Medical Information

1. Adult or pediatric with newly diagnosed Philadelphia chromosome positive (Ph+) CML in chronic phase
2. Adult with chronic phase and accelerated phase Ph+ CML
  - a. Resistant or intolerant to imatinib
3. Pediatric patient with chronic phase or accelerated phase Ph+ CML
  - a. Resistant or intolerant to prior TKI therapy

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## TAVALISSE

---

### Drugs

TAVALISSE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:

a. Pt has previous trial on previous therapy of at least ONE of the following:

- i. Corticosteroids
- ii. Immunoglobulins
- iii. Splenectomy
- iv. Thrombopoietin Receptor Agonist

b. Platelet count is less than 50000/micoL

2. Reauth:

a. Platelet count is greater than 50000/micoL

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 3 Months

Reauth: Plan Year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

## TAVNEOS

---

### Drugs

TAVNEOS

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Patient currently requires dialysis

### Required Medical Information

Initial:

1. Diagnosis of ANCA-associated vasculitis
2. ANCA-antibody titer test
3. BVAS score (1 major item, 3 non-major items, or 2 renal items of proteinuria and hematuria)
4. Patient is currently receiving rituximab or cyclophosphamide

Reauth:

1. Patient has experienced improvement in BVAS score

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 months

Reauth: 12 months

### Other Criteria

N/A

Updated 11/27/2023

## TAZVERIK

---

### Drugs

TAZVERIK

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx: Metastatic or locally advanced epithelioid sarcoma
  - a. Diagnosis confirmed by pathology
  - b. SMARCB1/INI1 deficient tumor
  - c. Tumor is not eligible for complete resection
2. Dx: Follicular lymphoma
  - a. Relapsed or refractory tumor
    - i. positive for EZH2 mutation
    - ii. Previous use of at least 2 prior systemic therapies
  - b. No satisfactory alternative treatment options available

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

Updated 11/27/2023

## TEFLARO

---

### Drugs

TEFLARO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For acute bacterial skin and skin structure infections:
  - a. Pt has had a positive culture within the past month for ANY of the following:
    - i. Staphylococcus aureus (MSSA and MRSA),
    - ii. Streptococcus pyogenes,
    - iii. Streptococcus agalactiae,
    - iv. Escherichia coli,
    - v. Klebsiella pneumonia,
    - vi. Klebsiella oxytoca,
2. For community-acquired bacterial pneumonia:
  - a. Pt has had a positive culture within the past month for ANY of the following:
    - i. Staphylococcus aureus (MSSA only),
    - ii. Streptococcus pneumoniae,
    - iii. Haemophilus influenzae,
    - iv. Escherichia coli,
    - v. Klebsiella pneumonia,
    - vi. Klebsiella oxytoca

### Age Restrictions

N/A

### Prescriber Restrictions

N/A  
Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

1 Month

**Other Criteria**

BvsD determination



**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**TEGSEDI**

---

**Drugs**

TEGSEDI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Initial:
  - a. Pt has applicable mutation to the TTR gene (V30M or V122I)
  - b. Pt has objective evidence of neuropathy based on bedside exam, nerve conduction studies, skin biopsy, and/or autonomic testing
  - c. Pt will have baseline and biweekly platelet counts and renal function labs
2. Reauth:
  - a. Pt has experience a clinical stabilization or improvement of neurologic impairment, motor function, cardiac function, and/or serum TTR levels

**Age Restrictions**

18 years old or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 6 months

Reauth: 6 months

**Other Criteria**

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**TEPMETKO**

---

**Drugs**

TEPMETKO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of NSCLS
  - A. Harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations
2. No known epidermal growth factor receptor (EGFR) activating mutations that predict sensitivity to anti-EGFR therapy
3. No known anaplastic lymphoma kinase (ALK) rearrangements that predict sensitivity to anti-ALK therapy

**Age Restrictions**

18 years of age and older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## THIORIDAZINE

---

### Drugs

THIORIDAZINE HCL

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Previous trial on BOTH of the following:
  - a. Fluphenazine, b. Molindone

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

**TIBSOVO**

---

**Drugs**

TIBSOVO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. AML newly diagnosed is susceptible isocitrate dehydrogenase-1 (IDH1) mutation
2. AML is susceptible isocitrate dehydrogenase-1 (IDH1) mutation and has relapsed or is refractory to one or more prior anticancer regimens
3. Locally advanced or metastatic cholangiocarcinoma with an isocitrate dehydrogenase-1 (IDH-1) mutation as detected by an FDA-approved test and is refractory to previous treatment

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**TOLCAPONE**

---

**Drugs**

TOLCAPONE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. The member is currently receiving carbidopa/levodopa therapy
2. Member is experiencing "off episodes" that requires adjunctive therapy and has failed at least two of the following: Entacapone, Ongentys, Dopamine agonist (pramipexole, ropinirole, etc), MAO B inhibitor (rasagiline, selegiline)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## TRIKAFTA

---

### Drugs

TRIKAFTA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Clinically significant cirrhosis

### Required Medical Information

1. Initial:
  - a. Pt has been genotyped by a FDA-approved CF mutation test and the mutation is responsive to Trikafta
2. Reauthorization:
  - a. Pt has been reassessed b. Pt's FEV1 has increased since initiation of Trikafta

### Age Restrictions

Granules: 2 to 5 years of age

Tablets: 6 years of age and older

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 3 months

Reauthorization: 12 months

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**TUKYSA**

---

**Drugs**

TUKYSA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Advanced unresectable or metastatic HER2-positive breast cancer
2. Used in combination with trastuzumab and capecitabine
3. At least 1 prior anti-HER2 based regimen in the metastatic setting

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**TURALIO**

---

**Drugs**

TURALIO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

- A. Diagnosis of Tenosynovial Giant Cell Tumor
- B. Condition is associated with severe morbidity or functional limitations
- C. Surgery will NOT improve status

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



## TYGACIL

---

### Drugs

TIGECYCLINE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For complicated bacterial skin and skin structure infections:

a. Pt has had a positive culture within the past month for ANY of the following:

i. Staphylococcus aureus (MSSA or MRSA), ii. Escherichia coli, iii. Enterococcus faecalis (vancomycin susceptible strains only), iv. Enterobacter cloacae, v. Klebsiella pneumonia, vi. Bacteroides fragilis, vii. Streptococcus agalactia, viii. S.pyogenes, ix. S.anginosus group (including S. anginosus, S. intermedius, and S. constellatus),

2. For community acquired bacterial pneumonia:

a. Pt has had a positive culture within the past month for ANY of the following:

- i. Streptococcus pneumonia (penicillin-susceptible isolates),
- ii. Haemophilus influenza (beta-lactamase negative isolates),
- iii. Legionella pneumophila,

3. For complicated bacterial intra-abdominal infections:

a. Pt has had a positive culture within the past month for ANY of the following:

i. Staphylococcus aureus (MSSA or MRSA), ii. Escherichia coli, iii. Enterococcus faecalis (vancomycin susceptible strains only), iv. Enterobacter cloacae, v. Klebsiella pneumonia, vi. K.oxytoca, vii. Bacteroides fragilis, viii. B.thetaiotaomicron, ix. B.uniformis, x. B.fragilis, xi. Citrobacter freundii, xii. Clostridium perfringens, xiii. Peptostreptococcus micros

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

1 Month

**Other Criteria**

BvsD determination

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**TYKERB**

---

**Drugs**

LAPATINIB DITOSYLATE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D and Some Medically Accepted Indications  
postmenopausal HER-2 receptor hormone receptor positive breast cancer in combination with an aromatase inhibitor

**Exclusion Criteria**

N/A

**Required Medical Information**

1. For advanced or metastatic HER-2 positive breast cancer dx:
  - a. Previous failure on anthracycline, taxane, and trastuzumab AND
  - b. Combination therapy with capecitabine OR
  - c. Combination therapy with trastuzumab,
2. For postmenopausal HER-2 receptor hormone receptor positive breast cancer dx:
  - a. Combination therapy with aromatase inhibitor

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**UBRELVY**

---

**Drugs**

UBRELVY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Patient has tried 2 generic triptan medications OR has a contraindication to the use of triptans (e.g. established cardiovascular disease or cerebrovascular disease)

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## UPTRAVI

---

### Drugs

UPTRAVI, UPTRAVI TITRATION PACK

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:
  - a. If pt has a positive vasoreactivity test:
    - i. Pt has failed maximum tolerated doses of calcium channel blockers,
  - b. Pt has previous trial on at least ONE of the following:
    - i. ambrisentan, ii. bosentan iii. Opsumit iv. Adempas
2. Reauth:
  - a. Pt has been reassessed within the past 6 months.

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

6 Months

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VALCHLOR**

---

**Drugs**

VALCHLOR

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has previous trial on at least ONE previous skin directed therapy of the following:
  - a. Topical corticosteroid, b. Topical carmustine, c. Topical retinoid, d. Radiation therapy, e. Phototherapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VANFLYTA**

---

**Drugs**

VANFLYTA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of newly diagnosed acute myeloid leukemia (AML) that is:

A. FLT3 internal tandem duplication (ITD)-positive as detected by FDA approved test

B. Will be taken in combination with standard cytarabine and anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## VASODILATORS

---

### Drugs

ORENITRAM, ORENITRAM TITRATION KIT M, TYVASO DPI MAINTENANCE KI, TYVASO DPI TITRATION KIT, VENTAVIS

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For Pulmonary Arterial Hypertension World Health Organization (WHO) Group 1:
  - A. Diagnosis is confirmed by right heart catheterization
  - B. One of the following:
    1. New York Heart Association (NYHA) functional class II or III:
      - a. Previous trial on at least one of the following:
        - i. Adcirca, ii. ambrisentan, iii. Opsumit, iv. sildenafil, v. bosentan,
    2. Presence of functional class IV
2. For Tyvaso requests with diagnosis of pulmonary hypertension associated with interstitial lung disease [World Health Organization (WHO) group 3]
  - A. Diagnosis is confirmed by right heart catheterization
  - B. Interstitial lung disease is diagnosed based on evidence of diffuse parenchymal lung disease
  - C. The patient is symptomatic

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year



**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**

BvsD Determination for Ventavis

## VELTASSA

---

### Drugs

VELTASSA

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Initial:

- a. If patient is on a ACE or ARB must meet BOTH of the following:
  - i. Pt has been tried on a loop or thiazide diuretic or has a contraindication to one of these diuretics,
  - ii. The dose of the ACE or ARB has been reduced in an attempt to lower serum potassium levels,
- b. Serum potassium levels above 5.1 mmol/L on two separate screenings,
- c. Pt has chronic kidney disease with an eGFR of 15 to 60 mL/min
- d. Pt has failed Lokelma

### Age Restrictions

18 years old or older

### Prescriber Restrictions

N/A

### Coverage Duration

Initial: 6 Months,

Reauth: Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VEMLIDY**

---

**Drugs**

VEMLIDY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Pt has decompensated hepatic impairment

**Required Medical Information**

Pt has previous trial on entecavir

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VENCLEXTA**

---

**Drugs**

VENCLEXTA, VENCLEXTA STARTING PACK

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. For CLL/SLL dx
2. For AML dx: a. Pt is ineligible for induction therapy OR b. Pt is 75 years or older

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**VERKAZIA**

---

**Drugs**

VERKAZIA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of vernal keratoconjunctivitis
2. Previous trial of TWO of the following:
  - a. Topical ophthalmic antihistamine
  - b. Topical ophthalmic mast cell stabilizer
  - c. Topical ophthalmic corticosteroid

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VERQUVO**

---

**Drugs**

VERQUVO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Pregnancy

**Required Medical Information**

1. Dx of chronic heart failure
  - A. New York Heart Association class II-IV
  - B. Left ventricular ejection fraction less than 45%
2. Previous hospitalization due to heart failure within the last 6 months or outpatient IV diuretic treatment within the last 3 months

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## VERZENIO

---

### Drugs

VERZENIO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of Early HR-positive, HER-2 negative, node positive breast cancer at high risk of recurrence
  - a. Will be used in combination with tamoxifen or aromatase inhibitor
2. Dx of Advanced or Metastatic breast cancer: Must meet a, b, OR c of the following:
  - a. Pt is receiving Verzenio in combination with an aromatase inhibitor
  - b. Pt has received prior endocrine therapy AND Verzenio will be given in combination with fulvestrant,
  - c. Pt has experienced disease progression following endocrine therapy and prior chemotherapy in the metastatic setting AND Verzenio will be used as monotherapy

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VIJOICE**

---

**Drugs**

VIJOICE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Confirmed/documented diagnosis of PIK3CA Related Overgrowth Spectrum (PROS)
  - a. Patient has mutation in the PIK3CA gene.

**Age Restrictions**

2 years of age or more

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**VITRAKVI**

---

**Drugs**

VITRAKVI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. solid tumor with a NTRK gene fusion
2. Metastatic or unable to have surgery
3. Received previous treatment

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VIVJOA**

---

**Drugs**

VIVJOA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Hx of recurrent vulvovaginal candidiasis, defined as at least 3 acute episodes in the last 12 months
2. Patient must be one of the following:
  - A. Post-menopausal
  - B. Not of reproductive potential (i.e. tubal ligation, hysterectomy, etc)
3. Patient has experienced a recurrence during or following 6 months of oral fluconazole maintenance therapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

14 weeks

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VIZIMPRO**

---

**Drugs**

VIZIMPRO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1) First line therapy 2) EGFR exon 19 deletion or EGFR exon 21 L858R substitution

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VONJO**

---

**Drugs**

VONJO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of intermediate or high-risk primary or secondary myelofibrosis (MF)
  - a. For secondary MF: post-polycythemia vera or post-essential thrombocytopenia
2. Documentation showing platelet counts below 50,000/mm<sup>3</sup> within the last 30 days
3. For intermediate risk: Inadequate response or intolerance to hydroxyurea, Pegasys, or Jakafi
4. For high risk: patient is not a candidate for transplant
5. Reauthorization: CBC and platelet count required. If above 50,000mm<sup>3</sup>, Vonjo is no longer indicated. Jakafi is approved for use in patients with platelet counts above 50,000/mm<sup>3</sup>

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 6 months

Reauthorization: Plan Year

**Other Criteria**

N/A

Updated 11/27/2023

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VOSEVI**

---

**Drugs**

VOSEVI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Confirmation of genotype

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 Weeks

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**VOTRIENT**

---

**Drugs**

VOTRIENT

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Soft Tissue Sarcoma dx:
  - a. Previous trial on at least ONE prior therapy
2. Advanced renal cell carcinoma dx

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## VOXZOGO

---

### Drugs

VOXZOGO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Current hypothyroidism or hyperthyroidism
2. Insulin-requiring diabetes mellitus
3. Autoimmune inflammatory disease or inflammatory bowel disease
4. Autonomic neuropathy
5. Renal insufficiency defined as serum creatinine greater than 2 mg/dL
6. Chronic anemia defined as hemoglobin (less than 13.5 g/dL in men, less than 12.0 g/dL in women) or hematocrit (less than 41.0% in men, less than 36.0% in women)
7. Baseline systolic blood pressure (BP) less than 70 millimeters of mercury (mm Hg) or recurrent symptomatic hypotension (defined as episodes of low BP generally accompanied by symptoms ie, dizziness, fainting) or recurrent symptomatic orthostatic hypotension
8. Cardiac or vascular disease
9. Clinically significant finding or arrhythmia on screening electrocardiogram (ECG) that indicates abnormal cardiac function or conduction or Fridericias corrected QTc-F greater than 450 msec
10. Untreated sleep apnea
11. Previous or expected bone-related surgery (ie. surgery involving disruption of bone cortex) within last/next 6 months
12. Unstable condition likely to require surgical intervention
13. Fracture of the long bones or spine within 6 months
14. Clinically significant hip injury
15. Slipped capital femoral epiphysis or avascular necrosis of the femoral head
16. History of or expected limb-lengthening surgery within last/next 18 months
17. In combination with growth hormone, insulin-like growth factor 1 (IGF-1), or anabolic steroids

### Required Medical Information

1. Dx of achondroplasia, confirmed by genetic testing
2. Ambulatory and able to stand without assistance

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**3. Reauthorization**

- A. Growth velocity greater than 1.5 cm/yr
- B. No evidence of growth plate closure (proximal tibia, distal femur)

**Age Restrictions**

5 years of age and older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Initial: 6 months

Reauth: 12 months

**Other Criteria**

BvD Determination



## VYNDAQEL

---

### Drugs

VYNDAMAX, VYNDAQEL

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

1. Use in combination with Onpattro or Tegsedi

### Required Medical Information

I. For cardiomyopathy of hereditary transthyretin-mediated amyloidosis (ATTR-CM)

A. Applicable mutation to the transthyretin (TTR) gene (e.g., Val122Ile, Thr60Ala, or Ile68Leu)

B. Clinical manifestations of amyloid fibrosis in the myocardium (e.g., AV bundle branch block, restrictive cardiomyopathy and heart failure with preserved ejection fraction [HFpEF])

II. For cardiomyopathy of wild type transthyretin-mediated amyloidosis (ATTR-CM)

B. Negative for monoclonal protein in blood or urine (evaluated by serum free light chains and serum protein electrophoresis with urine immunofixation)

C. Absence of monoclonal proteins has the patient undergone nuclear scintigraphy diagnosis OR presence of monoclonal proteins has the patient undergone tissue biopsy to rule out light chain cardiac amyloidosis

D. Clinical manifestations of amyloid fibrosis in the myocardium (e.g., AV bundle branch block, restrictive cardiomyopathy and heart failure with preserved ejection fraction [HFpEF])

### Age Restrictions

18 years of age or older

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

**WELIREG**

---

**Drugs**

WELIREG

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Requires immediate surgery

**Required Medical Information**

1. Dx von Hippel-Lindau (VHL) disease who require therapy for associated:
  - a. renal cell carcinoma (RCC)
  - b. central nervous system (CNS) hemangioblastomas
  - c. pancreatic neuroendocrine tumors (pNET)
2. Reauthorization: Patient is stable on therapy

**Age Restrictions**

18 years or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

**XALKORI**

---

**Drugs**

XALKORI

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Combination therapy with other chemotherapy agents

**Required Medical Information**

1. Dx with:

- a. metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)
- b. metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1-positive
- c. relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive
- d. unresectable, recurrent, or refractory ALK-positive inflammatory myofibroblastic tumor

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**XELJANZ**

---

**Drugs**

XELJANZ, XELJANZ XR

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

**Required Medical Information**

1. For RA, PsA, and JIA: Pt has previous trial on at least TWO of the following: a. Cosentyx, b. Enbrel, c. Humira, d. Renflexis, e. Rinvoq, f. Stelara g. Skyrizi
2. For UC: Pt has previous trial on at least TWO of the following: a. Entyvio, b. Humira, c. Renflexis, d. Stelara e. Rinvoq
3. For AS: Pt has previous trial on at least TWO of the following: a. Cosentyx, b. Enbrel, c. Humira, d. Renflexis, e. Rinvoq
4. Pt has failed a TNF inhibitor

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**XENAZINE**

---

**Drugs**

TETRABENAZINE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D and Some Medically Accepted Indications  
Tardive Dyskinesia

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of Moderate to severe chorea due to Huntington's Disease OR
2. Diagnosis of Tardive Dyskinesia

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

**XERMELO**

---

**Drugs**

XERMELO

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Initial:
  - a. Pt has more than 4 bowel movements a day despite treatment with sandostatin analog therapy for at least 3 months
  - b. Pt has previous trial of lomotil AND loperamide
  - c. Xermelo will be used in combination with sandostatin analog
2. Reauth:
  - a. Pt has experienced improvement in bowel movement frequency since starting Xermelo

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

6 Months

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**XGEVA**

---

**Drugs**

XGEVA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Must meet at least ONE of the following:

- a. Pt has giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity,
- b. Pt has a diagnosis of bone metastases related to a solid tumor,
- c. Pt has a diagnosis of metastatic breast or prostate cancer,
- d. Pt has previously been treated with Zometa and had disease progression OR adverse reaction to the treatment

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD determination

Part B before Part D Step Therapy



SelectHealth Medicare  
2023 Prior Authorization Criteria

**XHANCE**

---

**Drugs**

XHANCE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of Nasal Polyps.
2. Previous use of mometasone intranasal spray

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

12 months

**Other Criteria**

N/A

## XIFAXAN

---

### Drugs

XIFAXAN

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D and Some Medically Accepted Indications

1. Clostridium difficile infection

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of:
  - a. Clostridium difficile (C. diff.) infection
  - b. Hepatic encephalopathy (HE)
  - c. Irritable bowel syndrome (IBS)
  - d. Traveler's diarrhea
2. Diagnosis of Hepatic encephalopathy (HE)
  - a. Previous failure on or has intolerance to lactulose therapy
3. Diagnosis of Irritable bowel syndrome (IBS)
  - a. Previous failure of at least TWO antispasmodic or antibiotic treatments (e.g., amoxicillin-clavulanate, cephalexin, ciprofloxacin, dicyclomine, doxycycline, gentamicin, metronidazole, neomycin, trimethoprim-sulfamethoxazole)
4. Diagnosis of Clostridium difficile (C. diff) infection
  - a. Patient has experienced relapse after prior use of oral vancomycin

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## XOLAIR

---

### Drugs

XOLAIR

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

Used in combination with another biologic (e.g., Dupixent, Humira, Entyvio, and Otezla, etc.)

### Required Medical Information

1. For allergic asthma dx:
  - a. Pt has previous trial (or documented contraindication) of at least ONE of the following for at least 3 months:
    - i. Low, medium, or high dose Inhaled corticosteroid (ICS) and inhaled long-acting bronchodilator (LABA)
    - ii. Medium dose ICS and leukotriene receptor antagonist (LTRA)
    - iii. Medium dose ICS and theophylline,
    - iv. Medium dose ICS and long-acting muscarinic antagonist (LAMA)
  - b. Pt has failed oral corticosteroids
  - c. Pt has at least ONE of the following:
    - i. ER visit or hospitalization for asthma within past 6 months, OR
    - ii. Need for frequent office visits due to asthma evaluation
  - d. Pt's IgE level is greater than or equal to 30 IU/mL
  - e. Pt is less than 330 lbs. (150 kg),
2. For Chronic Spontaneous Urticaria (CSU) dx:
  - a. Pt has previous failure on a H-1 antagonist, (e.g., cetirizine, hydroxyzine)
  - b. Pt has previous failure of leukotriene receptor antagonist (LTRA) (e.g., montelukast)
3. Dx of Nasal Polyps
  - a. Previous use of systemic corticosteroid therapy
  - b. Patient has had previous failure of and will be used in combination with nasal corticosteroids

### Age Restrictions

N/A

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**XOSPATA**

---

**Drugs**

XOSPATA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Relapsed or refractory AML
2. patient has a FLT3 mutation detected by an FDA-approved test

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

plan year

**Other Criteria**

N/A

## XPOVIO

---

### Drugs

XPOVIO, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG TWICE WEEKLY

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Dx of relapsed or refractory multiple myeloma
  - a. Previous use of at least one prior therapies
2. Dx of diffuse large B-cell lymphoma
  - a. Previous use of at least two lines of systemic therapy

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## XTANDI

---

### Drugs

XTANDI

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Diagnosis of:
  - a. metastatic castration-resistant prostate cancer (mCRPC)
  - b. metastatic castration-sensitive prostate cancer (mCSPC)
  - c. Dx non-metastatic castration-resistant prostate cancer

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A



SelectHealth Medicare  
2023 Prior Authorization Criteria

**XURIDEN**

---

**Drugs**

XURIDEN

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Diagnosis of hereditary orotic aciduria

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## **XYREM**

---

### **Drugs**

SODIUM OXYBATE

### **Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

### **Exclusion Criteria**

1. Succinic semialdehyde dehydrogenase deficiency,
2. Concurrent use of alcohol, opiates, sedatives, hypnotics, or other drug that causes CNS depression

### **Required Medical Information**

1. Initial:
  - a. For narcolepsy without cataplexy:
    - i. exhibits symptoms of excessive daytime sleepiness
    - ii. intolerant to at least one stimulant,
    - iii. inadequate response to maximum recommended dose of modafinil or armodafinil, intolerant or allergy to modafinil and armodafinil, or pt is 17 years of age or less,
  - b. For narcolepsy with cataplexy:
    - i. exhibits symptoms of cataplexy
2. Reauth:
  - a. For narcolepsy: i. Decrease in daytime sleepiness,
  - b. For narcolepsy with cataplexy: i. Decrease in cataplexy episodes

### **Age Restrictions**

7 years of age or older

### **Prescriber Restrictions**

Board certified in Sleep, Pulmonology, or Neurology

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**YONSA**

---

**Drugs**

YONSA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of mCRPC
2. Abiraterone (Yonsa) will be given in combination with an oral corticosteroid

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

## ZARXIO

---

### Drugs

NEUPOGEN, RELEUKO, ZARXIO

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. Neutropenia
2. If requesting Neupogen, Releuko or Zarxio, pt has trial on BOTH of the following:
  - a. Nivestym, b. Granix

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

BvsD Determination

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ZAVESCA**

---

**Drugs**

MIGLUSTAT

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt was diagnosed with type 1 Gaucher disease by a Geneticist or consult
2. Pt is unable to use intravenous enzyme replacement

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ZEJULA**

---

**Drugs**

ZEJULA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer
  - a. Complete or partial response to first-line platinum-based chemotherapy
2. Deleterious or suspected deleterious germline BRCA-mutated (gBRCAmut) recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer
  - a. Complete or partial response to platinum-based chemotherapy

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ZELAPAR**

---

**Drugs**

ZELAPAR

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt diagnosed with Parkinson's
2. Pt is treated with carbidopa/levodopa and will continue to be treated with carbidopa/levodopa in combination with Zelapar
3. Pt has failed generic selegiline

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



## ZELBORAF

---

### Drugs

COTELLIC, ZELBORAF

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For Metastatic Melanoma dx:
  - a. Pt is BRAF V600E positive for Zelboraf monotherapy OR
  - b. BRAF V600E or V600K positive for Zelboraf plus Cotellic
2. For Erdheim-Chester Disease:
  - a. Zelboraf monotherapy
  - b. Pt is BRAF V600 positive

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

## ZEPOSIA

---

### Drugs

ZEPOSIA, ZEPOSIA 7-DAY STARTER PAC, ZEPOSIA STARTER KIT

### Covered Uses

Some FDA Approved Indications

### Exclusion Criteria

Combination therapy with another biologic medication, JAK inhibitor, or Otezla

### Required Medical Information

1. Diagnosis of ulcerative colitis
  - a. Patient has failed treatment with at least two of the following: Entyvio, Humira, Renflexis, Stelara, Rinvoq
2. For Dx of CIS, RRMS or aSPMS
  - a. Patient's diagnosis of multiple sclerosis is supported by the 2017 McDonald diagnostic criteria (Please select the appropriate diagnostic finding below based on number of attacks, number of lesions, and additional clinical data needed )?
    - i. Two attacks PLUS two lesions on MRI.
    - ii. Two attacks, one lesion, and evidence of dissemination in space on MRI.
    - iii. One attack, two lesions, and evidence of dissemination in time on MRI
    - iv. One attack, one lesion, and evidence of dissemination in space AND time on MRI. OR demonstration of CSF-specific oligoclonal bands.
    - v. One attack, one lesion, and evidence of dissemination in space on MRI AND demonstration of CSF-specific oligoclonal bands.
  - b. For new starts only, MRI findings been reviewed and interpreted by a radiologist to confirm the diagnosis and findings. Please note, radiologist interpretation must be submitted.

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

12 months

Updated 11/27/2023

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Other Criteria**  
N/A

**ZOLINZA**

---

**Drugs**

ZOLINZA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Pt has progressive, persistent, or recurrent disease,
2. Pt has tried at least TWO prior systemic therapies

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ZONISADE**

---

**Drugs**

ZONISADE

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Dx of partial-onset seizures
2. Inability to swallow tablets and capsules

**Age Restrictions**

16 years or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ZTALMY**

---

**Drugs**

ZTALMY

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. Confirmation of CDKL5 deficiency based on genetic testing
2. Trial and failure of at least two previous antiepileptic therapies

**Age Restrictions**

2 years of age or older

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ZYDELIG**

---

**Drugs**

ZYDELIG

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

N/A

**Required Medical Information**

1. CLL dx:
  - a. Used in combination with rituximab

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A

SelectHealth Medicare  
2023 Prior Authorization Criteria

**ZYKADIA**

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**Drugs**

ZYKADIA

**Covered Uses**

All FDA Approved Indications not otherwise excluded from Part D

**Exclusion Criteria**

1. Combination therapy

**Required Medical Information**

1. Dx with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Plan Year

**Other Criteria**

N/A



## ZYTIGA

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### Drugs

ABIRATERONE ACETATE

### Covered Uses

All FDA Approved Indications not otherwise excluded from Part D

### Exclusion Criteria

N/A

### Required Medical Information

1. For metastatic CRPC dx:
  - a. Abiraterone is given in combination with prednisone 5mg twice daily
2. For metastatic high-risk CSPC dx:
  - a. Abiraterone is given in combination with prednisone 5 mg once daily

### Age Restrictions

N/A

### Prescriber Restrictions

N/A

### Coverage Duration

Plan Year

### Other Criteria

N/A

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

**Index**

Actemra.....1	Cholbam .....39	Fintepla .....77
Actimmune.....2	Cimzia .....40	Firazyr.....78
Adempas .....3	Cometriq .....41	Firdapse.....79
Aimovig .....4	Copiktra.....42	Fotivda .....80
Airduo.....6	Cosentyx.....43	Galafold.....81
Ajovy .....7	Crinone.....44	Gattex.....82
Albenza.....9	Cromolyn Sol .....45	Gavreto .....83
Alecensa .....10	Cystagon.....46	Generic Advair.....84
Amphob.....11	Cystaran .....47	Gilotrif .....85
Androgens .....12	Cystic Fibrosis.....48	Gleostine .....86
Antibiotics .....13	Daurismo .....49	Glp 1 .....87
Antipsychotic.....14	Diacomit .....50	Growth Hormone .....88
Apo B.....15	Doptelet .....51	Haegarda .....90
Arcalyst.....17	Dronabinol .....52	Harvoni.....91
Arikayce.....18	Dulera .....53	Hemady .....92
Atopic Derm .....19	Dupixent.....54	Hepatitis C.....93
Austedo .....20	Emgality.....57	Hetlioz .....94
Auvelity .....21	Enbrel .....59	Humira .....95
Ayvakit.....22	Endari .....60	Humulin U500 .....97
Balversa.....23	Endothelin Antagonists .....61	Hyftor .....98
Banzel.....24	Enspryng.....62	Ibrance .....99
Benlysta.....25	Epclusa .....63	Iclusig .....100
Besremi .....26	Epidiolex.....64	Idhifa .....101
Bosulif .....27	Erivedge .....65	Ilumya.....102
Braftovi.....28	Erleada .....66	Imbruvica .....103
Brukinsa.....29	Esbriet .....67	Impavido .....104
Cablivi.....30	Ethacrynic Acid.....68	Inbrija .....105
Cabometyx .....31	Evrysdi .....69	Increlex.....106
Calquence.....32	Exkivity .....70	Inlyta .....107
Camzyos .....33	Extavia .....71	Inqovi .....108
Cancidas .....35	Fareston .....73	Inrebic .....109
Caprelsa.....36	Fasenra.....74	Iressa .....110
Carbaglu .....37	Fentanyl.....75	Isturisa.....111
Cerdelga .....38	Filspari.....76	Ivig.....113

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

Jadenu .....	114	Neulasta .....	155	Palynziq .....	196
Jakafi .....	115	Nexavar .....	156	Panretin.....	197
Jaypirca .....	117	Nexletol .....	157	Pcsk .....	198
Jynarque.....	118	Nexlizet .....	158	Pemazyre.....	199
Kalydeco .....	119	Nicotrol .....	159	Phenoxybenzamine.....	200
Kerendia .....	120	Ninlaro.....	160	Phosphate Binder.....	201
Keveyis .....	121	Nitrofurantoin .....	161	Piqray .....	202
Kevzara .....	122	Northera.....	162	Pomalyst.....	203
Kineret.....	123	Nourianz.....	163	Prefest .....	204
Kisqali .....	124	Noxafil .....	164	Pretomanid .....	205
Korlym .....	125	Npb Insulin .....	165	Prevymis.....	206
Koselugo.....	126	Nubeqa.....	166	Primaxin .....	207
Kynmobi .....	127	Nucala .....	167	Promacta .....	209
Lampit .....	128	Nuedexta.....	169	Proteinase Inhibitor .....	210
Lenvima .....	129	Nuplazid .....	170	Purixan .....	211
Lidoderm .....	131	Nurtec .....	171	Pyrukynd .....	212
Livtency .....	132	Nyvepria .....	172	Qbrexza .....	213
Lokelma.....	133	Ocaliva.....	173	Qinlock .....	214
Lonsurf .....	134	Octreotide .....	175	Qulipta.....	215
Lorbrena.....	135	Ofev.....	177	Radicava .....	216
Lucemyra.....	136	Ojjaara.....	179	Rcc.....	217
Lumakras.....	137	Olumiant .....	180	Relistor .....	219
Lupkynis .....	138	Onfi.....	181	Relyvrio .....	220
Lynparza .....	139	Onureg .....	182	Retevmo .....	221
Lytgobi.....	141	Orencia .....	183	Revcovi .....	222
Mavenclad.....	142	Orfadin .....	184	Revlimid .....	224
Mavyret.....	144	Orgovyx .....	185	Rexulti .....	225
Mekinist .....	145	Oriahnn .....	186	Reyvow.....	226
Migranal .....	146	Orilissa.....	187	Rezlidhia .....	227
Ms .....	147	Orkambi.....	188	Rezurock.....	228
Mulpleta.....	149	Orserdu .....	189	Riluzole .....	229
Myalept .....	150	Osteoporosis .....	190	Rinvoq .....	230
Mycapssa.....	151	Otezla .....	192	Rozlytrek .....	232
Nafcillin .....	152	Oxbryta.....	193	Rubraca .....	233
Narcolepsy .....	153	Oxervate.....	194	Rydapt .....	234
Nerlynx .....	154	Pah .....	195	Sabril .....	235

**SelectHealth Medicare  
2023 Prior Authorization Criteria**

Scemblix .....	236	Tykerb .....	275	Zarxio.....	317
Signifor .....	237	Ubrelyv.....	276	Zavesca.....	318
Sirturo .....	238	Uptravi .....	277	Zejula.....	319
Sitavig.....	239	Valchlor .....	278	Zelapar .....	320
Skyrizi .....	240	Vanflyta .....	279	Zelboraf .....	321
Somavert.....	241	Vasodilators .....	280	Zeposia .....	322
Sprycel.....	242	Veltassa .....	282	Zolinza .....	324
Stelara .....	243	Vemlidy .....	283	Zonisade.....	325
Stivarga .....	244	Venclexta.....	284	Ztalmy .....	326
Sucraid.....	245	Verkazia.....	285	Zydelig.....	327
Sutent.....	246	Verquvo.....	286	Zykadia .....	328
Symdeko.....	247	Verzenio .....	287	Zytiga.....	329
Synarel.....	248	Vijoice.....	288		
Synribo .....	249	Vitrakvi .....	289		
Syprine .....	250	Vivjoa.....	290		
Tabrecta .....	251	Vizimpro .....	291		
Tafinlar .....	252	Vonjo .....	292		
Tagrisso .....	253	Vosevi.....	293		
Takhzyro.....	254	Votrient .....	294		
Talzenna .....	255	Voxzogo.....	295		
Tarceva .....	256	Vyndaqel .....	297		
Targretin.....	257	Welireg.....	299		
Tasigna .....	258	Xalkori .....	300		
Tavalisse .....	259	Xeljanz .....	301		
Tavneos .....	261	Xenazine .....	302		
Tazverik .....	262	Xermelo.....	303		
Teflaro .....	263	Xgeva.....	304		
Tegsedi .....	265	Xhance.....	305		
Tepmetko .....	266	Xifaxan.....	306		
Thioridazine.....	267	Xolair .....	308		
Tibsovo .....	268	Xospata .....	310		
Tolcapone.....	269	Xpovio .....	311		
Trikafta .....	270	Xtandi .....	312		
Tukysa .....	271	Xuriden.....	313		
Turalio .....	272	Xyrem .....	314		
Tygacil .....	273	Yonsa.....	316		