ACTIMMUNE

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

AKEEGA

Drugs
AKEEGA

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC)
2. Contraindication, intolerance, or failure of Lynparza

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

ALBENZA

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

ALECENSA

Drugs
ALECENSA, ALUNBRIG

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. For Alecensa:
   A. Diagnosis of ONE of the following:
      i. anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC)
      ii. adjuvant treatment in adult patients following tumor resection of ALK-positive NSCLC (tumors greater than or equal to 4 cm or node positive)
2. For Alunbrig:
   B. Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

AMPHOB

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. For use of brand Ambisome:
   a. Pt must have previous failure or contraindication to generic Amphotericin B,
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

ANDROGENS

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

ANTIPSYCHOTIC

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

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,

2. Reauthorization: 12 mo

Other Criteria
N/A

ARCALYST

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

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

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

Updated 6/26/2024

AUGTYRO

Drugs
AUGTYRO

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC)
2. Contraindication, intolerance, or failure of Rozlytrek

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

AUSTEDO

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

AUVELITY

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

AYVAKIT

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 including PDGFRA D842V mutations
b. Advanced Systemic Mastocytosis: AdvSM includes patients with aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL).
c. Indolent Systemic Mastocytosis

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

BALVERSA

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

BANZEL

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

Drugs
BENLYSTA

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
Use in severe active CNS lupus

Required Medical Information
1. Diagnosis of lupus nephritis or systemic lupus erythematosus
2. Pt is currently autoantibody positive,
3. Pt has current active disease,
4. Pt has previous treatment with at least TWO of the following:
   a. Corticosteroids, b. Antimalarials, c. Immunosuppressives,
5. 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

Updated 6/26/2024

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

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

BRAFTOVI

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 BRAF V600E or V600K mutation-positive unresectable or metastatic melanoma
    a. Will be used as combination therapy with encorafenib [Braftovi] and binimetinib [Mektovi]
2. For encorafenib [Braftovi], dx of BRAF V600E mutation-positive metastatic colorectal cancer
    a. Will be used as combination therapy with cetuximab [Erbitux]
3. Dx of BRAF V600E mutation-positive metastatic non-small cell lung cancer (NSCLC)
    a. Will be used as combination therapy with encorafenib [Braftovi] and binimetinib [Mektovi]

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
12 months

Other Criteria
N/A

BRONCHITOL

Drugs
BRONCHITOL

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of cystic fibrosis
2. Trial of both Hypersal and sodium chloride (3% or 7%)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

BRUKINSA

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
      d. Chronic lymphocytic leukemia (CLL)/ Small lymphocytic lymphoma (SLL)
      e. Relapsed or refractory follicular lymphoma (FL)
2. Patient has received at least one prior therapy for MCL
3. Patient has been previously treated with anti-CD20-based regimen for MZL
4. Patient has received two or more lines of therapy for FL and Brukinsa will be used in combination with obinutuzumab

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A
Updated 6/26/2024

CABLIVI

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
3 months

Other Criteria
Max Duration of therapy 58 days

Updated 6/26/2024

CABOMETYX

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

CALQUENCE

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

CANCIDAS

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

CAPRELSA

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

CARBAGLU

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
Plan year

Other Criteria
N/A

CHOLBAM

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. Patient has experienced improvement in ALT/AST values, bilirubin values, and/or weight

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: Plan year
Reauth: 12 months

Other Criteria
N/A

COMETRIQ

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

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

CRINONE

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

CROMOLYN SOL

Drugs
CROMOLYN SODIUM

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of mastocytosis or mast cell activation syndrome
2. Failure of TWO of the following:
   A. Type 1 or Type 2 histamine receptor blocker
   B. Montelukast

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
Plan year

Other Criteria
N/A

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

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

DOPTELET

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

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

DUPIXENT

Drugs
DUPIXENT

Covered Uses
Some FDA Approved Indications

Exclusion Criteria
1. Use in combination with any other biologic (e.g., Dupixent, Xolair, Humira, Entyvio, and Otezla, etc.)

Required Medical Information
1. Diagnosis of corticosteroid-dependent asthma (Please note, Dupixent is only covered for corticosteroid-dependent asthma)
    A. Diagnosis of corticosteroid-dependent asthma evidenced by member's requirement of at least 3 months of chronic oral corticosteroids
2. 3 month failure of at least TWO of the following:
    A. ICS + SABA
    B. ICS/LABA
    C. Spiriva or Trelegy
    D. LTRA
3. Two provider/ER/Hospital admissions for asthma exacerbations within the last 12 months

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist or Allergist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/26/2024

EMGALITY

Drugs
EMGALITY

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of episodic cluster headache
2. Diagnosis of Episodic Migraine (4-14 migraine days per month) or Chronic Migraine (greater than 14 migraine days per month)
    A. Member has tried Ajovy

Reauthorization Criteria:
1. Patient has had a reduction in the number of migraine days per month

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

ENDARI

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

ENDOTHELIN ANTAGONISTS

Drugs
AMBRISENTAN, BOSENTAN

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

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: Plan year
Reauthorization: 12 months

Other Criteria
N/A

Updated 6/26/2024

EPCLUSA

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

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

ERIVEDGE

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

ERLEADA

Drugs
ERLEADA

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Patient has tried and failed abiraterone 250mg AND
2. Must meet at least ONE of the following:
   A. Erleada will be given combination with a gonadotropin-releasing hormone analog
   B. Patient has had a bilateral orchietomy

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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 6/26/2024

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

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

Age Restrictions
N/A

Prescriber Restrictions
Pediatric Neurologist or Neurologist

Coverage Duration
Initial: 6 months
Reauthorization: 12 months

Other Criteria
N/A

EXKIVITY

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
12 months

Other Criteria
N/A

FARESTON

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

FENTANYL

Drugs
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
N/A

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

FILSUVEZ

Drugs
FILSUVEZ

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
Combination use with Vyjuvek

Required Medical Information
1. Dx of dystrophic or junctional epidermolysis bullosa
2. Prescribing physician is a dermatologist with experience in treating epidermolysis bullosa and collaborated with a wound healing specialist
3. Reauthorization:
    a. Documentation of a response as evidenced by wound healing

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist

Coverage Duration
Initial: 6 months
Reauth: Plan Year

Other Criteria
N/A

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

FIRAZYR

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 aquired 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

FIRDAPSE

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 6/26/2024

FOTIVDA

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

FRUZAQLA

Drugs
FRUZAQLA

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of metastatic colorectal cancer (mCRC)
2. Member has previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type and medically appropriate, an anti-EGFR therapy
3. Member has failed, contraindication, or intolerance to Lonsurf with or without bevacizumab

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
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 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

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

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

GLP 1

Drugs
MOUNJARO, TRULICITY

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
Type 1 diabetes mellitus

Required Medical Information
1. Dx of type 2 diabetes
2. Failure of SGLT2 or DPP-4 as evidenced by an A1c greater than 7% within the last 3 months after a 90-day trial with an SGLT-2 or DPP-4 OR has contraindication (reduced renal function, urinary frequency due to BPH, LUTS, bladder spasm, recurrent genital fungal infection, recurrent urinary tract infection)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

GROWTH HORMONE

Drugs
GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN 10, NUTROPIN AQ NUSPIN 20, NUTROPIN AQ NUSPIN 5, OMNITROPE, 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:
   A. Male at bone age of 16 yo, Female at bone age of 14 yo, Fusion of epiphyses
   B. 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. HIV wasting: 48 wks LIFETIME,
2. All other indications: Plan Year

Other Criteria
1. For Zomacton, Humatrope, Norditropin, & Nutropin: Patient has tried BOTH Omnitrope and Genotropin
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 megesterol 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.

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

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

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

HETLIOZ

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
AMJEVITA, HADLIMA, HADLIMA PUSHTOUCH

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. Dx of AS, UC, or CD
2. Dx of 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, OR contraindication to use (Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, Pregnancy, breastfeeding, or currently planning pregnancy, Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), Elevated liver transaminases, Hypersensitivity, or history of intolerance or adverse event, Interstitial pneumonitis or clinically significant pulmonary fibrosis, Myelodysplasia, Renal impairment
3. Dx of hidradenitis suppurativa:
   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. Dx of noninfectious uveitis:
   a. Pt has previous failure on corticosteroids
5. Dx of plaque psoriasis: Pt has failed therapy with at least ONE of the following:
   a. methotrexate, b. cyclosporine, c. acitretin

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

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,

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

ICLUSIG

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

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

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
    b. Prescribing physician is a specialist in transplant

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

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

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 50x10^9/L

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Updated 6/26/2024

Other Criteria
N/A

IVIG

Drugs
BIVIGAM, 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

IWILFIN

Drugs
IWILFIN

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of high risk neuroblastoma (HRNB) in patients who have demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy
2. Maximum duration of 2 years of therapy

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

IXCHIQ

Drugs
IXCHIQ

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
Confirmation that the patient is at increased risk of exposure to chikungunya virus

Age Restrictions
18 years of age or older

Prescriber Restrictions
N/A

Coverage Duration
1 month

Other Criteria
N/A

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
Part B before Part D step therapy

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-polychythemia vera myleofibrosis, 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 50X10(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 6/26/2024

Other Criteria
N/A

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

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

KALYDECO

Drugs
KALYDECO

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   A. Pt genotyped by an FDA-cleared CF mutation test
   B. Pt have one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data
   C. Pt has FEV1 between 40-90%
2. Reauth:
   A. Pt has been reassessed since starting therapy,
   B. Pt's FEV1 has increased since starting therapy

Age Restrictions
Tablet: 6 years old or older,
Granules: 1 months old to 5 years old

Prescriber Restrictions
Specialist in Cystic Fibrosis or Pulmonologist

Coverage Duration
Initial: 3 months
Reauth: 12 months

Other Criteria
N/A
Updated 6/26/2024

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/m2 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 6/26/2024

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. Dx of hormone receptor (HR)-positive, human epidermal growth factor 2 (HER-2)-negative advanced or metastatic breast cancer, 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 fluvestrant 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
MIFEPRISTONE

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

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

KYNMOBI

Drugs
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 6/26/2024

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

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 6/26/2024

Other Criteria
N/A

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 intoleranct of first line antiviral treatment (e.g., ganciclovir, valganciclovir, foscarnet, or cidofovir)

Age Restrictions
N/A

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. Reauthoriation:
   a. serum potassium of less than 5.5 mmol/L while on treatment

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial 6 months, Reauthorization 12 months

Other Criteria
N/A

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

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 thearpy (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 6/26/2024

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/1.73m2

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. 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
   b. 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
   b. BRCA-mutated (BRCAm) metastatic castration resistant prostate cancer (mCRPC) in combination with abiraterone and prednisone or prednisolone

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

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

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

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-metreleptin antibodies,
   b. If presence of anti-metreleptin 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 6/26/2024

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

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

NEULASTA

Drugs
FYLNETRA, NEULASTA, STIMUFEND, 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 Fylnetra Neulasta, Stimufend, or Ziextenzo, 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

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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
N/A

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

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

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

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 treatment of invasive aspergillus
2. For aspergillus or candida prophylaxis:
   a. Pt is at high risk of developing infections secondary to being severely immunocompromised,
3. 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

NPB INSULIN

Drugs
INSULIN DEGLUDEC, INSULIN DEGLUDEC FLEXTOUC, 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. Patient has failed BOTH Lantus & Toujeo or has documented intolerance to Lantus and/or Toujeo?

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

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

NURTEC

Drugs
NURTEC

Covered Uses
Some FDA Approved Indications

Exclusion Criteria
N/A

Required Medical Information
1. For Acute Treatment of Migraines (Please note: Nurtec is only covered for acute treatment of migraines, prophylaxis dosing is not covered):
    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)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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 imunoabsorbant 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

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
Plan year

Other Criteria
BvsD determination

OFEV

Drugs
OFEV

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

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. 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

Other Criteria
N/A

OGSIVEO

Drugs
OGSIVEO

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of desmoid tumor/aggressive fibromatosis with documentation of tumor progression
2. Contraindication, intolerance, or failure of sorafenib

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

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), including primary MF or secondary MF (postpolycythemia vera (PV) and post-essential thrombocytopenia (ET))
2. Hemoglobin less than 10g/dL
3. Member 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

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

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

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

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/26/2024

ORIAHNN

Drugs
MYFEMBREE, ORIAHNN

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. For Oriahnn: Dx of Heavy menstrual bleeding associated with uterine leiomyomas (fibroids)
2. For Myfembree: Dx of Heavy menstrual bleeding associated with uterine leiomyomas (fibroids) or Moderate to Severe Pain Associated with Endometriosis
3. Premenopausal
4. Previous use of a combination oral contraceptive
5. Previous use of a progestin-only contraceptive

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year, maximum lifetime duration 24 months

Other Criteria
N/A

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 Orilissa 150 mg, maximum lifetime duration 24 months
6 months 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 genotyped by an FDA-cleared CF mutation test
    B. Pt has cystic fibrosis with the homozygous F508del mutation in the CTFR gene that has been confirmed by an FDA approved test,
    C. Pt has FEV1 between 40-90%
2. Reauth
    A. Pt has been reassessed since starting therapy,
    B. Pt's FEV1 has increased since starting therapy

Age Restrictions
Tablet: 6 years old or older,
Granules: 1 year old to 5 years old

Prescriber Restrictions
Specialist in Cystic Fibrosis or Pulmonologist

Coverage Duration
Initial: 3 months
Reauth: 12 months

Other Criteria
N/A
Updated 6/26/2024

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: 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

Updated 6/26/2024

Coverage Duration
Plan year

Other Criteria
BvD Determination

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

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. Pt is diagnosed with pulmonary arterial hypertension, confirmed by right heart catheterization
  b. Pt with positive vasoreactivity test:
    i. Pt has contraindications to or failed maximum tolerated doses of calcium channel blockers,
    c. For Tadliq and sildenafil oral suspension requests: Inability to swallow tablets
2. Reauth:
  a. Pt has been reassed within the past 6 months

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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 sapropterin 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

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 , untreated LDL-C greater than 500mg/dL or treated LDL-C greater than 300mg/dL
i. AND cutaneous or tendon xanthoma before age 10 years, OR
ii. Elevated LDL-C levels consistent with heterozygous FH in both parents
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

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

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

PREFERRED MS

Drugs
COPAXONE, TECFIDERA, TECFIDERA STARTER PACK, VUMERITY

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
1. In combination with other Multiple sclerosis (MS) modifying therapies [i.e., Ocrevus, Tecfidera (dimethyl fumarate), Tysabri, etc.)
2. Other neuroinflammatory disease (e.g., neuromyelitis optica)
3. Treatment plan contains combination with another biologic medication, Janus kinase (JAK) inhibitor or Otezla

Required Medical Information
1. Dx of:
   a. Active form of secondary progressive Multiple sclerosis (aSPMS)
   b. Clinically isolated syndrome (CIS)
   c. Relapsing remitting multiple sclerosis (RRMS)
2. Patient dx of MS is supported by ONE of the following 2017 McDonald diagnostic criteria:
   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 (documentation must be submitted)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

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

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. For: CMV prophylaxis in HSCT recipients
    a. Pt is post allogenic hematopoietic stem cell transplant within the last 28 days
    b. Pt is a CMV-seropositive recipient [R+]
2. For: CMV prophylaxis in kidney transplant recipients
    a. Pt is post kidney transplant within last 7 days
    b. Pt is high risk (Donor CMV seropositive/Recipient CMV seronegative)
3. Medication will be discontinued on or before 200 days post-transplantation

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
200 days

Other Criteria
N/A

Updated 6/26/2024

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, immunoglubulins, 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 6/26/2024

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

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

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

QULIPTA

Drugs
QULIPTA

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of Episodic Migraine (4-14 migraine days per month) or Chronic Migraine (greater than 14 migraine days per month)
2. Member has trial on prophylactic therapy on at least TWO of the following:
    A. Anti-Epileptic (ie topiramate, valproic acid)
    B. Beta-blocker (ie atenolol, bisoprolol, metoprolol, nadolol, nebivolol, pindolol, propranolol, timolol)
    C. Anti-depressant (ie amitriptyline, nortriptyline, venlafaxine)

Reauthorization Criteria:
1. Patient has had a reduction in the number of migraine days per month

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: Plan Year
Reauthorization: Plan Year

Other Criteria
N/A

Updated 6/26/2024

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: Plan year
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

Updated 6/26/2024

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

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
6 months initial, 12 months reauthorization

Other Criteria
N/A

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 6/26/2024

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, OR
      b. As maintenance following autologous hematopoietic stem cell transplantation (auto HSCT)
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 imitediate-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

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

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

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 Rezurock following at least 30 days of therapy
Reauthorization
3. Documentation of stable or improved disease

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
12 months

Other Criteria
N/A
Updated 6/26/2024

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
3. For the oral pellets: patient has inability to swallow capsules and solution made from capsules.

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, VIGPODER

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. For solution:
   a. For infantile spasms:
      i. Must be used as monotherapy
   b. For refractory complex partial seizures
2. For tablets:
   a. Must be used as adjunctive therapy,
   b. Must have tried at least TWO of the following:
      i. Rufinamide, ii. Carbamazepine, iii. Celontin, iv. Dilantin, v. Divalproex, vi. Epitol, vii. Equetro, viii. Ethosuximide, ix. Felbamate, x. Tiagabine, xi. Lamictal, xii. Lamotrigine, xiii. Levetiracetam, xiv. Pregabalin, xv. Primidone, xvi. Oxcarbazepine, xvii. Phenytoin, xviii. Topiramate, xix. Valproic Acid, xx. Lacosamide, xxi. Zonisamide

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
1. Periodic vision testing

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 crotisol 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: Plan year
Reauth: Plan Year

Other Criteria
N/A

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

SOHONOS

Drugs
SOHONOS

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of fibrodysplasia ossificans progressiva (FOP) confirmed by genetic testing (documentation must be submitted)

Age Restrictions
Females age 8 years or older and Males age 10 years or older

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, somatuline depot, or lanreotide

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

STELARA

Drugs
STELARA

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
Combination therapy with another biolgic 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

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

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

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
Plan year

Other Criteria
N/A

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

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

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

TALTZ

Drugs
TALTZ

Covered Uses
Some FDA Approved Indications

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

Required Medical Information
1. Dx of Ankylosing Spondylitis (Please note, Taltz is not covered for indications other than Ankylosing spondylitis)
2. Member has tried adalimumab

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

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. 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

TARPEYO

Drugs
TARPEYO

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
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) greater than or equal to 0.8 g/g
3. eGFR greater than or equal to 35 mL/min/1.73 m2
4. Stable at maximally tolerated dose of RAS therapy
5. Failure of three months of Filspari

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
9 months, no reauthorization

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

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 6/26/2024

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 6/26/2024

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

Coverage Duration
1 Month

Other Criteria
BvsD determination

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 months
Reauth: 6 months

Other Criteria
BvsD Determination

Updated 6/26/2024

TEPMETKO

Drugs
TEPMETKO

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of metastatic non-small cell lung cancer (NSCLC) harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations.

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

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

TRUQAP

Drugs
TRUQAP

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
1. diabetes mellitus type 1, type 2, requiring insulin treatment or HbA1c greater than or equal to 8%

Required Medical Information
1. Dx of HR-positive, HER2-negative, locally advanced or metastatic breast cancer
2. Patient has PIK3CA/AKT1/PTEN-alterations.
    A. If PIK3CA, patient must have failed Piqray
3. Patient has failed at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy
4. Truqap with be used in combination with fulvestrant

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

TUKYSA

Drugs
TUKYSA

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. For RAS wild-type unresectable or metastatic HER2-positive breast cancer
    a. Used in combination with trastuzumab and capecitabine
2. For unresectable or metastatic colorectal cancer
    a. Used in combination with trastuzumab
    b. Following treatment with fluoropyrimidine, oxaliplatin, and irinotecan based chemotherapy

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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 isotales),
      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

Coverage Duration
1 Month

Other Criteria
BvsD determination

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

Updated 6/26/2024

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

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

VANFLYTA

Drugs
VANFLYTA

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Newly diagnosed acute myeloid leukemia that is FLT3 internal tandem duplication (ITD)-positive as detected by an FDA approved test.
2. Will be taken in combination with standard cytarabine and anthracycline induction, 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

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. tadalfil (Adcirca), ii. ambrisentan, iii. sildenafil, iv. 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

Updated 6/26/2024

Other Criteria
N/A

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: Plan Year
Reauth: Plan Year

Other Criteria
N/A

Updated 6/26/2024

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

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

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

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

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

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

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 EFGR exon 21 L858R substitution

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
12 months

Other Criteria
N/A

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/mm3 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 50,000mm3, Vonjo is no longer indicated. Jakafi is approved for use in patients with platelet counts above 50,000/mm3

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 months
Reauthorization: Plan Year

Other Criteria
N/A

Updated 6/26/2024

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

VOTRIENT

Drugs
PAZOPANIB HYDROCHLORIDE

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

Updated 6/26/2024

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

Age Restrictions
N/A

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Updated 6/26/2024

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
N/A

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

XELJANZ

Drugs
XELJANZ, XELJANZ XR

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. Dx of RA, JIA, PsA: Pt has failed at least three months therapy on at least ONE of the following:
a. methotrexate, b. leflunomide, c. hydroxychloroquine, d. sulfasalazine, OR contraindication to use (Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease, Pregnancy, breastfeeding, or currently planning pregnancy, Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), Elevated liver transaminases, Hypersensitivity, or history of intolerance or adverse event, Interstitial pneumonitis or clinically significant pulmonary fibrosis, Myelodysplasia, Renal impairment
2. Dx of RA, JIA, PsA, UC, AS: Pt has failed a TNF inhibitor

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

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

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 metasteses 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

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 encephalopthy (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

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.)
Used in combination with Palforzia

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 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. For Nasal Polyps dx
   a. Previous use of systemic corticosteroid therapy
   b. Patient has had previous failure of and will be used in combination with nasal corticosteroids
4. For IgE-mediated food allergy dx
   a. Documentation supports pt has a history of type 1 (IgE-mediated) food allergy

b. Diagnosis of IgE mediated food allergy is confirmed through positive skin prick test or positive serum IgE
c. Pt body weight and documented pretreatment IgE levels are within the dosing recommendations based on the FDA prescribing information
d. Pt will continue with food allergen avoidance, where appropriate
e. For Reauthorization: Documentation must show the patient has experience a significant reduction in frequency or severity of incidental exposure reactions

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
For IgE-mediated food allergy: 6 months
For all other indications: Plan Year

Other Criteria
BvsD Determination

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. Patient has tried and failed abiraterone 250mg AND
2. 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

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

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

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

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

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

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
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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

ZURZUVAE

Drugs
ZURZUVAE

Covered Uses
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Dx of moderate to severe PPD
2. Major Depressive episode began in third trimester of pregnancy or within 4 weeks following delivery
3. Treatment will be initiated less than or equal to 12 months after delivery
4. Maximum duration 14 days per pregnancy

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
1 month

Other Criteria
N/A

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

ZYKADIA

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

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

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