ACTEMRA

Drugs
ACTEMRA, ACTEMRA ACTPEN

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Oncologist, Pulmonologist, or consult

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

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

ADEMPAS

Drugs
ADEMPAS

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

Exclusion Criteria
N/A

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

Age Restrictions
18 years old or older

Prescriber Restrictions
Specialist in pulmonary hypertension

Coverage Duration
Plan Year

Other Criteria
N/A

AIMOVIG

Drugs
AIMOVIG

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 Months
Reauth: Plan Year

Other Criteria
N/A

AJOVY

Drugs
AJOVY

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 Months
Reauth: Plan Year

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. Dx of NSCLC that is ALK-positive

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

AMPHOB

Drugs
AMBISOME, AMPHOTERICIN B

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, TESTOSTERONE TOPICAL SOLU

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,
3. Previous trial on generic testosterone topical or gel

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

ANTIBIOTICS

Drugs
BAXDELA, DALVANCE, NUZYRA, SIVEXTRO, XENLETA

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

Exclusion Criteria
N/A

Required Medical Information
Medication to be dosed based on FDA approved dosing

Age Restrictions
N/A

Prescriber Restrictions
Infectious disease specialist or after consultation with an infectious disease specialist

Coverage Duration
1 month

Other Criteria
N/A

ANTIPSYCHOTIC

Drugs
CAPLYTA, FANAPT, FANAPT TITRATION PACK, LATUDA, LYBALVI, 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
Cardiologist or Endrocrinologist

Coverage Duration
1. Initial: 6 mo,

2. Reauthorization: 12 mo

Other Criteria
BvsD Determination

APOKYN

Drugs
APOKYN, APOMORPHINE HYDROCHLORIDE

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

Exclusion Criteria
N/A

Required Medical Information
1. Pt suffering from end of dose wearing off episodes,
2. Apomorphine initiated with a concomitant antiemetic (not a 5HT3)

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

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
Pulmonologist, Infectious Disease Specialist

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

Age Restrictions
18 years of age or older

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

Updated 6/27/2022

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
b. Advanced Systemic Mastocytosis

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Allergist, or Immunologist

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
18 years of age or older

Prescriber Restrictions
Urologist, nephrologist, or oncologist

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
Neurologist

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 lupus nephritis or severe active CNS lupus

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist or Nephrologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

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
Oncologist

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, hematologist, or dermatologist

Coverage Duration
12 months

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
2. Patient has received at least one prior therapy for MCL
3. Patient has been previously treated with anti-CD20-based regimen for MZL

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist or Consult

Coverage Duration
Plan Year

Other Criteria
N/A

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
18 years or older

Prescriber Restrictions
Hematologist

Coverage Duration
3 months

Other Criteria
N/A

Updated 6/27/2022

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

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
Oncologist or Hematologist

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
Oncologist, Hematologist, or Endocrinologist

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
Specialist in Medical Genetics or Metabolic Specialist

Coverage Duration
6 Months

Other Criteria
N/A

CERDELGA

Drugs
CERDELGA

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

Exclusion Criteria
N/A

Required Medical Information
1. Pt was diagnosed by a Clinical Biomedical Geneticist,
2. Pt is unable to use intravenous enzyme replacement,
3. The CYP2D6 genotype has been determined

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

CHOLBAM

Drugs
CHOLBAM

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist

Coverage Duration
Initial: 6 months,
Reauth: 12 months

Other Criteria
N/A

Updated 6/27/2022

CIMZIA

Drugs
CIMZIA

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Gastroenterologist, Dermatologist, or consult

Coverage Duration
Plan Year

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, mestatic medullary thyroid cancer (MMTC)
   b. Relapsed or Stage IV (unresectable or mestatic) renal cell cancer (RCC)
   C. Hepatocellular carcinoma
2. Administered in combo or without Opdivo (Note: Opdivo requires preauthorization)
3. Max daily dose of 80 mg/day"

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or consult

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
hematologist or oncologist

Coverage Duration
12 months

Other Criteria
N/A

COSENTYX

Drugs
COSENTYX, COSENTYX SENSOREADY PEN

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist, Rheumatologist, or consult

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/27/2022

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
Diagnosis of mastocytosis

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

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
Nephrologist or Endocrinologist

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
Corneal Specialist or Ophthalmologist

Coverage Duration
6 Months

Other Criteria
N/A

Updated 6/27/2022

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
Pulmonologist or Infectious Disease Specialist

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
Oncologist or hematologist

Coverage Duration
Plan year

Other Criteria
N/A

DEPEN

Drugs
PENICILLAMINE

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

Exclusion Criteria
N/A

Required Medical Information
1. For cystinuria dx:
   a. Pt has failure of conservative treatment measures including the following:
      i. High fluid intake,
      ii. Sodium and protein restriction,
      iii. Urinary alkalization with potassium citrate, potassium bicarbonate, or acetazolamide,
   b. Pt has previous failure with Thiola.

Age Restrictions
N/A

Prescriber Restrictions
Nephrologist, Endocrinologist, or Rheumatologist

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
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

DIFICID

Drugs
DIFICID

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

Exclusion Criteria
N/A

Required Medical Information
1. Pt has had a positive C. difficile toxin assay within the past month,
2. Pt has tried the following treatments:
   a. Vancomycin for 10-14 days,
   b. Vancomycin extended taper,

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist or Infectious Disease Specialist

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
Hematologist, Hepatologist, or Surgeon

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
All FDA Approved Indications not otherwise excluded from Part D

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of moderate to severe atopic dermatitis (AD)
    A. Greater than or equal to 10 percent body surface area coverage
    B. Failure of two of the following:
        i. Topical corticosteroid (e.g., fluocinonide, clobetasol, etc.)
        ii. Topical calcineurin inhibitor (eg. tacrolimus ointment 0.1%)
        iii. Phototherapy
        iv. Oral immunomodulator (azathioprine, cyclosporine, methotrexate, or mycophenolate)
        v. Topical PDE-4 (Eucrisa)
2. Diagnosis of moderate to severe asthma with eosinophilic pheontype
    A. Previous use of an Inhaled corticosteroid (ICS) AND one of the following:
        i. Inhaled corticosteroid/Long-acting beta-agonist (ICS/LABA)
        ii. Long-acting muscarinic antagonist (LAMA) (Spiriva) or ICS/LABA/LAMA (Trelegy)
        iii. Leukotriene receptor antagonist (LTRA)
    B. Peripheral blood eosinophil level greater than 150 cells/mcL
    C. One or more exacerbations requiring the use of oral corticosteroids in the previous 12 months
3. Chronic oral corticosteroid dependent asthma
    A. Chronic oral corticosteroid therapy for at least the last 3 months
    B. Previous use of an Inhaled corticosteroid (ICS) AND one of the following:
        i. Inhaled corticosteroid/Long-acting beta-agonist (ICS/LABA)
        ii. Long-acting muscarinic antagonist (LAMA) (Spiriva) or ICS/LABA/LAMA (Trelegy)
        iii. Leukotriene receptor antagonist (LTRA)

4. Reauthorization steroid dependent asthma:
   A. reduction in chronic corticosteroid therapy and shown improvement in symptoms
5. Chronic rhinosinusitis with nasal polyps:
   A. Previous use of at least two weeks of systemic corticosteroid therapy
   B. Failed at least two weeks of intranasal corticosteroid therapy
6. Reauthorization for rhinosinusitis with nasal polyps:
   A. reduction in their nasal polyp size and nasal congestion

Age Restrictions
6 years old or older

Prescriber Restrictions
Allergist, Dermatologist, Immunologist, ENT, or Pulmonologist

Coverage Duration
Plan Year

Other Criteria
N/A

EMGALITY

Drugs
EMGALITY

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 Months
Reauth: Plan Year

Updated 6/27/2022

Other Criteria
N/A

ENBREL

Drugs
ENBREL, ENBREL MINI, ENBREL SURECLICK

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Dermatologist, Gastroenterologist, or consult

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
5 years of age or older

Prescriber Restrictions
Hematologist specializing in treatment of Sickle Cell Disease (SCD)

Coverage Duration
Plan Year

Other Criteria
N/A

ENDOTHELIN ANTAGONIST

Drugs
AMBRISENTAN, BOSENTAN, OPSUMIT, TRACLEER

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

Exclusion Criteria
N/A

Required Medical Information
1. Exclusion of all secondary causes of pulmonary hypertension,
2. Must be dx with PAH with WHO class II, III, or IV
3. Previous use of sildenafil or tadalafil

Age Restrictions
N/A

Prescriber Restrictions
Pulmonoligist or Cardiologist

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
18 years of age or older

Prescriber Restrictions
Neurologist or ophthalmologist

Coverage Duration
Initial: 6 months
Reauthorization: 12 months

Other Criteria
N/A

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
Gastroenterologist, Infectious Disease Specialist, or Transplant Specialist

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
Neurologist

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
Dermatologist or Oncologist

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
Must meet at least ONE of the following:
1. Erleada will be given combination with a gonadotropin-releasing hormone analog
2. Patient has had a bilateral orchietomy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

ESBRIET

Drugs
ESBRIET

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
Pulmonologist

Coverage Duration
Initial: 3 mo,
Reauth: 1 year

Other Criteria
N/A
Updated 6/27/2022

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

EVENITY

Drugs
EVENITY

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

Exclusion Criteria
Myocardial infarction or stroke in the last 12 months

Required Medical Information
1. Patient is female
2. Patient is postmenopausal
3. Diagnosis of osteoporosis (t-score less than -2.5) or osteopenia (t-score of -1.0 to -2.5)
4. Previous use of both:
   A. Bisphosphonate therapy
   B. Prolia
5. At least one of the following:
   A. Previous osteoporotic fracture
   B. Bone loss based on the results of DEXA scans showing 10 percent or greater bone loss at spine or hip over the past two years
   C. A fasting morning serum C-telopeptide less than 200 pg/ml OR a 24-hour urine N-telopeptide less than 50 nM BCE/mM creatinine

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist, rheumatologist, gynecologist, orthopedist, or mid-level provider with a supervising physician in one of these specialties

Coverage Duration
Plan Year

Updated 6/27/2022

Other Criteria
N/A

EVRYSDI

Drugs
EVRYSDI

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

Exclusion Criteria
1. Prior use of onasemnogene abeparvovec (Zolgensma)

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

Age Restrictions
2 months of age or older

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
18 years of age or older

Prescriber Restrictions
N/A

Coverage Duration
12 months

Other Criteria
N/A

EXTAVIA

Drugs
EXTAVIA

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

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

Required Medical Information
I. Initial authorization
A. Diagnosis of CIS, RRMS, or SPMS
B. Previous use of ONE generic of:
1. Dimethyl fumerate, glatiramer, Glatopa
C. Previous use of ONE preferred:
1. Avonex, Gilenya, Ocrevus, Plegridy, Tysabri
D. CBC within previous 6 months
E. LFT within previous 6 months
F. Dx of MS supported by 2017 McDonald diagnostic criteria
1. Two attacks PLUS two lesions on MRI OR two attacks, one lesion, and evidence of dissemination in space on MRI OR one attack, two lesions, and evidence of dissemination in time on MRI OR one attack, one lesion, and evidence of dissemination in space AND time on MRI, OR demonstration of CSF specific oligoclonal bands OR one attack, one lesion, and evidence of dissemination in space on MRI AND demonstration of CSF-specific oligoclonal bands,
II. Reauthorization
A. Patient is stable on therapy

Age Restrictions
18 years of age or older

Prescriber Restrictions
Neurologist

Updated 6/27/2022

Coverage Duration
Plan Year

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
Oncologist

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
N/A

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

Age Restrictions
12 years of age or older

Prescriber Restrictions
Allergist, Pulmonologist, Rheumatologist, Hematologist, or Endocrinologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

FENTANYL

Drugs
FENTANYL CITRATE, FENTANYL CITRATE ORAL TRA

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

Exclusion Criteria
Non-cancer pain use

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Pain Specialist

Coverage Duration
6 Months

Other Criteria
Previous trial on generic fentanyl patches

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 Gastaut syndrome
2. Previous use of two of topiramate, valproic acid, or clobazam

Age Restrictions
2 years of age or older

Prescriber Restrictions
Neurologist or epileptologist

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
Allergist or Immunologist

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
Neurologist

Coverage Duration
Initial: 3 months
Reauthorization: 6 months

Other Criteria
N/A
Updated 6/27/2022

FORTEO

Drugs
TERIPARATIDE

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

Exclusion Criteria
1. Treatment for longer than 2 years

Required Medical Information
1. For osteoporosis dx:
   a. Required WHO FRAX has been completed and pt is determined to be high risk with a 10 year hip fracture probability of greater than 10%,
   b. Pt is intolerant or has a contraindication to Tymlos,
   c. Pt has previous use of Prolia and failed therapy as evidenced by fragility fracture or a decline in bone mineral density of greater than 10% while on therapy.

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

FOTIVDA

Drugs
FOTIVDA

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

Exclusion Criteria
N/A

Required Medical Information
Previous failure of two systemic therapies

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or consult

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
amenable galactosidase alpha gene variant

Age Restrictions
16 years of age or older

Prescriber Restrictions
Clinical geneticist, biochemical geneticist, or Nephrologist

Coverage Duration
Plan year

Other Criteria
N/A

GATTEX

Drugs
GATTEX

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Gastroenterologist

Coverage Duration
Initial: 6 months,
Reauth: Plan Year

Other Criteria
N/A

GAVRETO

Drugs
GAVRETO

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

Exclusion Criteria
N/A

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

Age Restrictions
18 and older for NSLC or 12 and older for thyroid cancer

Prescriber Restrictions
Oncologist

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. Metastatic Squamous NSCLC dx:
   a. Progression after platinum-based chemotherapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

GLP

Drugs
BYDUREON BCISE, BYETTA, TRULICITY

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

Exclusion Criteria
Type 1 diabetes mellitus

Required Medical Information
1. Dx type 2 diabetes mellitus
2. Pediatric patients between 10 and 18 years of age
3. For Adult type 2 diabetes patients, allow if one of:
   a. Previous use of SGLT-2 or DPP-IV inhibitor
   b. Decreased renal function (eGFR 45mL/min/m2 or less)
   c. Urinary frequency due to BPH, LUTS, bladder spasm
   d. Recurrent genital fungal infection
   e. Recurrent urinary tract infection

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/27/2022

GROWTH HORMONE

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

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
Ped GHD AND Adult GHD: Endocrinologist or nephrologist

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

Other Criteria
1. Chronic Renal Insufficiency:
Updated 6/27/2022

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,

2. 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,

3. 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,

4. 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,

5. 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
Allergist or Immunologist who evaluates and treats HAE

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
Gastroenterologist, Infectious Disease Specialist, or Transplant Specialist

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
Oncologist or consult

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
Gastroenterologist, Hepatologist, or Infectious Disease

Coverage Duration
48 weeks

Other Criteria
N/A

HETLIOZ

Drugs
HETLIOZ, HETLIOZ LQ

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Sleep specialist or Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

HUMIRA

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

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Dermatologist, Gastroenterologist, Ophthalmologist, or consult

Coverage Duration
Plan Year

Other Criteria
N/A

HUMULIN U500

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

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

Exclusion Criteria
N/A

Required Medical Information
1. Requires more than 200 units of insulin per day

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

IBRANCE

Drugs
IBRANCE

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

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
Oncologist or Hematologist

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
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

ILUMYA

Drugs
ILUMYA

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

IMBRUVICA

Drugs
IMBRUVICA

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

Exclusion Criteria
N/A

Required Medical Information
Pt has failed at least ONE prior therapy

Age Restrictions
N/A

Prescriber Restrictions
1. cGVHD: Transplant Specialist
2. All other dx: Oncologist or Hematologist

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
Infectious disease specialist or consult

Coverage Duration
28 days

Other Criteria
N/A

INBRIJA

Drugs
INBRIJA

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

Exclusion Criteria
Asthma, COPD, or other chronic lung disease

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

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

INCRELEX

Drugs
INCRELEX

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

Exclusion Criteria
N/A

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

Age Restrictions
2 years old or older

Prescriber Restrictions
Endocrinologist or consult

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
Oncologist

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
Oncologist or hematologist

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
Oncologist or hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

IRESSA

Drugs
IRESSA

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. Iressa is used as first-line therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

ISTURISA

Drugs
ISTURISA

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

Exclusion Criteria
N/A

Required Medical Information
1. Dx of Cushings Disease
   a. Baseline mean urinary free cortisol (UFC) level at least 1.5x the upper limit of normal measured over three 24 hour measurements (ULN = 50 micrograms/24 hours or 145 nmol/24 hours)
   b. Symptoms of Cushings Disease (e.g diabetes, central obesity, moon face, buffalo hump, osteoporosis, muscle wasting, hypertension, depression, anxiety)
   c. Failure of pituitary surgery or contraindication to pituitary surgery
   d. Intolerance to pasireotide (Signifor)
   g. Exclusion of other causes of Cushings Syndrome (aside from Cushings Disease which is specifically caused by a pituitary adenoma)
2. For reauthorization:
   a. Recent UFC level showing improvement (less than 48 weeks of treatment) or is within normal limits (after 48 weeks of treatment)
   b. Symptom improvement of Cushings Disease

Age Restrictions
18 years and older

Prescriber Restrictions
Endocrinologist

Coverage Duration
Plan Year

Other Criteria
N/A

IVIG

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

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD determination

JADENU

Drugs
DEFERASIROX

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

Exclusion Criteria
N/A

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

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

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
Part B before Part D step therapy

Updated 6/27/2022

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
Nephrologist

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

Age Restrictions
Tablet: 6 years old or older,
Granules: 4 months old to 5 years old

Prescriber Restrictions
Pulmonologist

Coverage Duration
Plan Year

Other Criteria
N/A

KERENDIA

Drugs
KERENDIA

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

Exclusion Criteria
N/A

Required Medical Information
1. Diagnosis of Type 2 Diabetes
   a. Prior treatment with one SGLT-2 inhibitor (Farxiga or Jardiance)
   b. Contraindication to SGLT2 inhibitor
      i. eGFR 45ml/min/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
Neurologist or in consult with neurologist

Coverage Duration
Initial: 6 months
Reauthorization: 12 months

Other Criteria
N/A
Updated 6/27/2022

KEVZARA

Drugs
KEVZARA

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

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

Required Medical Information
1. Pt has previous trial on at least TWO of:
   a. Enbrel, b. Humira, c. Renflexis, d. Rinvoq

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

KINERET

Drugs
KINERET

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

KISQALI

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

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

Exclusion Criteria
N/A

Required Medical Information
1. Must meet ONE of the following:
   a. Pt will receive an aromatase inhibitor in combination with Kisqali as initial endocrine based therapy for advanced or metastatic disease,
   b. Pt will receive fluvestrant in combination with Kisqali AND is pt postmenopausal

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

KORLYM

Drugs
KORLYM

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

Exclusion Criteria
Pt using long-term corticosteroid

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

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist

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
Neurologist, Medical Geneticist

Coverage Duration
Plan Year

Other Criteria
N/A

KYNMOBI

Drugs
KYNMOBI

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

Age Restrictions
N/A

Prescriber Restrictions
Neurologist or movement disorder specialist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/27/2022

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
18 years of age or younger

Prescriber Restrictions
Infectious disease specialist or in consult with

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 6/27/2022

Other Criteria
N/A

LIDODERM

Drugs
LIDOCAINE

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

Exclusion Criteria
N/A

Required Medical Information
1. Dx of post-herpetic neuralgia

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

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
12 years of age or older

Prescriber Restrictions
N/A

Coverage Duration
8 weeks

Other Criteria
N/A

LOKELMA

Drugs
LOKELMA

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

Exclusion Criteria
N/A

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

Age Restrictions
18 years of age or older

Prescriber Restrictions
N/A

Coverage Duration
Initial 6 months, Reauthorization 12 months

Other Criteria
N/A

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
Oncologist

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
Oncologist

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

Age Restrictions
18 years of age or older

Prescriber Restrictions
Psychiatry, Addiction medicine, or Pain management

Coverage Duration
14 Days

Other Criteria
N/A

LUMAKRAS

Drugs
LUMAKRAS

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

Exclusion Criteria
N/A

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
Oncologist or consult

Coverage Duration
Initial: 6 months
Reauthorization: 12 months

Other Criteria
N/A

Updated 6/27/2022

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
Rheumatologist or Nephrologist

Coverage Duration
Plan Year

Other Criteria
N/A

LYNPARZA

Drugs
LYNPARZA

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

Exclusion Criteria
Combination therapy

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

MAVENCLAD

Drugs
MAVENCLAD

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

Exclusion Criteria
Not covered in combination with other treatments for MS

Required Medical Information
I. Initial authorization
A. Diagnosis of RRMS or SPMS
B. Previous use of ONE generic of:
1. Dimethyl fumerate, glatiramer, Glatopa
C. Previous use of ONE preferred:
1. Avonex, Gilenya, Ocrevus, Plegridy, Tysabri
D. CBC within previous 6 months
E. LFT within previous 6 months
F. Dx of MS supported by 2017 McDonald diagnostic criteria
1. Two attacks PLUS two lesions on MRI OR two attacks, one lesion, and evidence of dissemination in space on MRI OR one attack, two lesions, and evidence of dissemination in time on MRI OR one attack, one lesion, and evidence of dissemination in space AND time on MRI, OR demonstration of CSF specific oligoclonal bands OR one attack, one lesion, and evidence of dissemination in space on MRI AND demonstration of CSF-specific oligoclonal bands,
II. Reauthorization
A. CBC in previous 6 months
B. Lymphocyte count at least 800 cells per microliter before initiating the second treatment course

Age Restrictions
18 years of age or older

Prescriber Restrictions
Neurologist

Updated 6/27/2022

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
Gastroenterologist, Infectious Disease Specialist, or Transplant Specialist

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Hematolgist, or Dermatologist

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
18 years old or older

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

MS

Drugs
AVONEX, AVONEX PEN, DIMETHYL FUMARATE, DIMETHYL FUMARATE STARTER, GILENYA, GLATIRAMER ACETATE, GLATOPA, PLEGRIDY

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

Exclusion Criteria
Other neuroinflammatory diseasae (e.g neuromyelitis optica)

Required Medical Information
1. Dx of CIS, RRMS, or active secondary progressive MS
2. Is diagnosis supported by McDonald diagnostic criteria one of: i. two attacks, plus two lesions on MRI, ii. two attacks, one lesion, and evidence of dissemination in space on MRI, iii. one attack, two lesions, and evidence of dissemination in time on MRI, iv. one attack, one lesion, and evidence of dissemination in space AND time on MRI or demonstration of CSF-specific oligoclonal bands, v. one attack, one lesion, and evidence of dissemination in space on MRI and demonstration of CSF-specific oligoclonal bands
3. CBC within previous 6 months
4. LFT within previous 6 months
5. For Avonex, Gilenya, or Plegridy, previous use of ONE of the following
   i. dimethyl fumarate, glatiramer acetate, Glatopa
6. For reauthorization, patient is currently stable on therapy

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

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
Endocrinologist

Coverage Duration
Initial: 6 months,
Reauth: Plan Year

Other Criteria
N/A
Updated 6/27/2022

MYCAPSSA

Drugs
MYCAPSSA

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist, oncologist, or consult

Coverage Duration
Plan Year

Other Criteria
N/A

NAFCILLIN

Drugs
NAFCILLIN SODIUM

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
BvsD determination

NATPARA

Drugs
NATPARA

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
Endocrinologist

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
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

NEULASTA

Drugs
FULPHILA, NEULASTA, UDENYCA, ZIEXTENZO

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

Exclusion Criteria
N/A

Required Medical Information
1. Neutropenia
2. If requesting Neulasta 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
NEXAVAR

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

Age Restrictions
N/A

Prescriber Restrictions
Cardiologist, endocrinologist, or other provider specializing in lipid disorders

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

Age Restrictions
N/A

Prescriber Restrictions
Cardiologist, endocrinologist, or other provider specializing in lipid disorders

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
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

NITROFURAN

Drugs
NITROFURANTOIN

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

Exclusion Criteria
N/A

Required Medical Information
1. Unable to swallow nitrofurantoin capsules

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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
Cardiologist or Neruologist

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. Using 3 or more daily doses of carbidopay/levodopa
3. Previous ue 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
Neurologist

Coverage Duration
Plan Year

Other Criteria
N/A

NOXAFIL

Drugs
NOXAFIL, POSACONAZOLE DR

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

Exclusion Criteria
N/A

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

Age Restrictions
1. For aspergillus or candida prophylaxis: 2 years old or older

Prescriber Restrictions
N/A

Coverage Duration
6 Months

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
B. Given in combination with GnRH analog OR has had bilateral orchiectomy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

NUCALA

Drugs
NUCALA

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

Exclusion Criteria
N/A

Required Medical Information
1. For Severe Asthma:
   A. Pt has a hx of 1 or more exacerbations requiring the use of oral corticosteroids in the past 12 months,
   B. Pt has previously been on all of the following:
      i. High-dose corticosteroid/Long-acting inhaled bronchodilator combination
      ii. Tiotropium bromide,
   C. Pt peripheral blood eosinophil level is greater than or equal to 150 cells/mcL within the last 6 months OR greater than equal to 300 cells/mcL within the last 12 months
2. For diagnosis of hypereosinophilic syndrome (HES)
   a. Verified diagnosis of HES for greater than or equal to 6 months without an identifiable non-hematologic secondary cause
   b. History of at least two HES flares (HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy) within the past 12 months
   c. Blood eosinophil count of greater than or equal to 1,000 cells/mcL
   d. Stable HES therapy for 4 weeks prior to treatment (chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy)
3. For Chronic Rhinosinusitis with Nasal Polyps (CRwNP)
   A. Failed at least two weeks of systemic corticosteroid therapy
   B. Failed at least two weeks of intranasal corticosteroid therapy
   C. For reauthorization, Reduction in nasal polyp size and nasal congestion

Age Restrictions
6 years of age and older

Prescriber Restrictions
Allergist, Pulmonologist, Rheumatologist, Hematologist, Endocrinologist, or Otolaryngologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

NUEDEXTA

Drugs
NUEDEXTA

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
6 Months

Other Criteria
N/A

NUPLAZID

Drugs
NUPLAZID

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Neurologist or Psychiatrist

Coverage Duration
Initial: 3 months,
Reauth: 12 months

Other Criteria
N/A

NURTEC

Drugs
NURTEC

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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
Gastroenterologist or Transplant Specialist

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
Endocrinologist, Oncologist, or Gastroenterologist

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

Updated 6/27/2022

Other Criteria
BvsD determination

OFEV

Drugs
OFEV

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

Exclusion Criteria
Pt is receiving anticoagulation therapy

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

Age Restrictions
N/A

Prescriber Restrictions
Pulmonoligist

Coverage Duration
Initial: 3 mo,
Reauth: 1 year

Other Criteria
N/A

OLUMIANT

Drugs
OLUMIANT

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

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

Required Medical Information
1. Pt has previous trial on at least TWO of the following:
   a. Enbrel, b. Humira, c. Renflexis, d. Rinvoq

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist or consult

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
Neurologist OR
For non-Lennox-Gastaut indications: Epileptologist

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
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A

OPIOID

Drugs
FENTANYL, HYDROMORPHONE HCL ER, HYDROMORPHONE HYDROCHLORI, METHADONE HCL, MORPHINE SULFATE ER, OXYCODONE HCL ER, OXYMORPHONE HYDROCHLORIDE, XTAMPZA ER

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

Exclusion Criteria
1. Taking benzodiazepine in combination with opioid,
   a. If yes,
i. The Food and Drug Administration (FDA) has issued a black box warning regarding the risks associated with using both an opioid and a benzodiazepine, which include profound sedation, respiratory depression, coma and death. Use of a benzodiazepine in a patient taking opioids should be limited to patients who have failed alternative treatment options. Has this patient failed alternative treatments?
ii. Additionally, per the black box warning, dose and duration of the benzodiazepine should be limited to the minimum required. Does the submitted information contain a plan for when the benzodiazepine will be discontinued?

Required Medical Information
1. Currently on hospice, or being treated for cancer pain OR,
2. Dx requiring long-acting opioid for pain management,
   a. Patient has a medication management agreement plan with the prescriber,
   b. Review of patients State Prescription Drug Monitoring Program (PDMP) record reviewed for concerns of overuse or misuse,
   c. The prescriber will monitor for medication misuse, sedation, or other concerns and take immediate action to reduce dose and/or wean to cessation of opioid if concerns are observed or suspected,
d. Prescriber attests to understanding observational data that show long-term opioid therapy is associated with an increased risk for serious harm (opioid use disorder, overdose, and death) in a dose-dependent manner and that the benefits of opioid therapy outweigh the risks for this patient?
   e. Patient been prescribed or offered naloxone and discussion taken place with the regarding the risks of high-dose opioid therapy,
   f. Benefits of the request outweigh the risks for this patient,
   g. There is a documented opioid treatment plan,
   h. If the current treatment exceeds the quantity limit, does the treatment plan include a plan to lower the total daily opioid dose? Please note, a plan to reduce the dose of any medication that is part of the patient¿s opioid regimen will be accepted as long as it results in a lower overall total daily dose.
   i. If unable to taper the dose

i. Was there an attempt to taper the dose,
ii. Provide the clinical rationale for inability to taper the dose,

3. If requesting Xtampza or oxycodone ER, has there been previous use of two alternative long-acting opioids (e.g. fentanyl, morphine ER, tramadol ER)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
6 Months

Other Criteria
N/A

ORENCIA

Drugs
ORENCIA, ORENCIA CLICKJECT

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist or consult

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

ORFADIN

Drugs
NITISINONE, NITYR, ORFADIN

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

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. Diagnosis is 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
Medical Geneticist or Metabolic Specialist

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
18 years of age or older

Prescriber Restrictions
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/27/2022

ORIAHNN

Drugs
MYFEMBREE, ORIAHNN

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Obstetrician gynecologist

Coverage Duration
Plan Year

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
Obstetrician gynecologist

Coverage Duration
12 months for Orilissa 150 mg
6 months for Orilissa 200 mg

Other Criteria
N/A

ORKAMBI

Drugs
ORKAMBI

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

Exclusion Criteria
Pt has history of solid organ transplant

Required Medical Information
1. Initial:
   a. Pt has cystic fibrosis with the homozygous F508del mutation in the CTFR gene that has been confirmed by an FDA approved test,
   b. If pt has been previously colonized with an organism associated with rapid decline in pulmonary function:
      1) Pt has had 2 negative respiratory tract cultures for the organism with in the last 12 months
2. Reauth:
   a. Pt has been reassessed since starting therapy,
   b. Pt's FEV1 has increased since starting therapy

Age Restrictions
2 yo and older

Prescriber Restrictions
Pulmonologist or midlevel provider in a clinic that specializes in the treatment of cystic fibrosis

Coverage Duration
Initial: 3 Months,
Reauth: 12 Months

Other Criteria
BvsD Determination

Updated 6/27/2022

OTEZLA

Drugs
OTEZLA

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

Exclusion Criteria
Combination therapy with another biologic medication or JAK inhibitor

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Dermatologist, or consult

Coverage Duration
Plan Year

Other Criteria
N/A

OXBRYTA

Drugs
OXBRYTA

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

Exclusion Criteria
N/A

Required Medical Information
1. Initial Authorization:
   A. Hemoglobin level between 5.5 and 10.5 g/dL
   B. One or more painful acute sickle cell crises within the past 12 months
   C. Is not receiving regular red-cell transfusion therapy
   D. Previously tried, is currently on, or has a contraindication to hydroxyurea
2. Reauthorization
   A. Experienced an increase in hemoglobin level of at least 1 g/dL

Age Restrictions
N/A

Prescriber Restrictions
Hematologist

Coverage Duration
6 months

Other Criteria
N/A

Updated 6/27/2022

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
Ophthalmologist

Coverage Duration
2 months

Other Criteria
N/A

PAH

Drugs
SILDENAFIL CITRATE, TADALAFIL

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

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. PAPm greater than or equal to 25 mmHG AND PCWP less than or equal to 15 mmHG,
   b. Pt with positive vasoreactivity test:
      i. Pt has contraindications to or failed maximum tolerated doses of calcium channel blockers,
2. Reauth:
   a. Pt has been reassess within the past 6 months

Age Restrictions
N/A

Prescriber Restrictions
Pulmonoligist or Cardiologist

Coverage Duration
Plan Year

Other Criteria
1. Tadalafil requests: previous trial on sildenafil

PALYNZIQ

Drugs
PALYNZIQ

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Medical Geneticist or consult

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
Oncologist or Infectious Disease Specialist or consult

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
B. Dx of HeFH or primary hyperlipidemia with fasting LDL-C of 190 mg/dL or greater on at least two separate dates at least 3 months apart
i. AND LDL-C remains greater than 100 mg/dL despite treatment on medication therapy
C. Dx of ASCVD consisting of MI, stroke, TIA, persistent intermittent claudication, coronary intervention revascularization or angina with proven ischemia
i. AND LDL-C remains greater than 70 mg/dL despite treatment on medication therapy

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/27/2022

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
2. Fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

PHENOXYBENZAMINE

Drugs
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

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
Nephrologist or in consult with

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
Oncologist

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
Oncologist or Hematologist

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
Pulmonologist, Infectious disease specialist

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Hematologist, Transplant Specialist, or Infectious Disease Specialist

Coverage Duration
100 days

Other Criteria
BvsD Determination

PRIMAXIN

Drugs
IMIPENEM/CILASTATIN

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

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

Required Medical Information
1. For infections of the lower respiratory tract, urinary tract, intra-abdominal, gynecologic, bone and joint, skin and skin structure, polymicrobic infections, or bacterial septicemia:
   a. Pt has had a positive culture within the past month for ANY of the following:
      i. Staphylococcus aureus (MSSA),
      ii. Streptococcus spp.,
      iii. Escherichia coli,
      iv. Klebsiella spp.,
      v. Enterobacter,
      vi. Pseudomonas aeruginosa,
      vii. Other resistant gram-negative bacilli,
      vii. Other anaerobes,
2. Pt must meet ONE of the following:
   a. Pt has a CrCl greater than or equal to 5 mL/minute/1.73 m2,
   b. Pt will be on hemodialysis within 48 hours of therapy,
3. Pt has failed at least ONE previous antibacterial and/or other antimicrobial therapy

Age Restrictions
N/A

Prescriber Restrictions
Infectious Disease Specialist

Coverage Duration
1 Month

Other Criteria
BvsD determination

PROMACTA

Drugs
PROMACTA

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

Exclusion Criteria
N/A

Required Medical Information
1. For ITP dx:
   a. Previous failure to corticosteroids, 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
For ITP: Oncologist or Hematologist

Coverage Duration
6 Months

Other Criteria
N/A
Updated 6/27/2022

PROTEINASE INHIBITOR

Drugs
ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Pulmonolgist specializing in treatment of Alpha-1 antitrypsin deficiency or COPD

Coverage Duration
Plan Year

Other Criteria
BvsD Determination

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
Oncologist or Hematologist

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
3. Patient taking at least 0.8mg folic acid/day

Age Restrictions
18 years of age or older

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
9 years of age and older

Prescriber Restrictions
Dermatologist

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
Oncologist

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. Diagnosis of Episodic Migraine
2. Trial of:
    A. Ajovy AND
    B. One of: Aimovig OR Emgality

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
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 Sutent 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 less 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
Oncologist or Neurologist

Coverage Duration
Plan Year

Updated 6/27/2022

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
12 years of age and older

Prescriber Restrictions
Oncologist

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. At least one of the following:
        i. Increase in plasma ADA activity (target trough level greater than or equal to 15 mmol/hr/L
        ii. Red blood cell dATP level decreased (target less than or equal to 0.005 to 0/015 mmol/L)
        iii. Improvement in immune function with diminished frequency/complications of infection as evidenced in improvement in the ability to produce antibodies
        iv. Improvement in red blood cell dAXP levels (target trough level less than or equal to 0.02 mmol/L)

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan year

Other Criteria
N/A

REVLIMID

Drugs
LENALIDOMIDE, REVLIMID

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

Exclusion Criteria
N/A

Required Medical Information
1. For Multiple Myeloma dx:
   a. Used in combination with dexamethasone,
2. For MCL:
   a. Pt has previous trial on bortezomib AND pt has trial on at least ONE other previous therapy
3. For transfusion-dependent anemia due to myelodysplastic syndrome
   a. Low or 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
Oncologist or Hematologist

Coverage Duration
Plan Year

Other Criteria
N/A
Updated 6/27/2022

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

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
Reauthorization
2. Documentation of stable or improved disease

Age Restrictions
12 years of age or older

Prescriber Restrictions
Transplant Specialist or Oncologist

Coverage Duration
12 months

Other Criteria
N/A

RILUZOLE

Drugs
EXSERVAN

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Neurologist experienced in the treatment of ALS OR consult

Coverage Duration
12 months

Other Criteria
N/A

RINVOQ

Drugs
RINVOQ

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

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

Required Medical Information
1.Diagnosis of moderate to severe active rheumatoid arthritis OR psoriatic arthritis
A. Pt has failed at least three months therapy on at least ONE of the following:
.i. methotrexate, ii. leflunomide, iii. hydroxychloroquine, iv. sulfasalazine, v. injectable gold, vi. oral gold, vii. azathioprine, viii. penicillamine, ix. cyclosporine,
B. Pt has tried and failed a TNF inhibitor
2.Diagnosis of moderate to severe atopic dermatitis (AD)
A. Greater than or equal to 10 percent body surface area coverage
B. Failure of two the following:
i. Topical corticosteroid (e.g., fluocinonide, clobetasol, etc.)
ii Topical calcineurin inhibitor (tacrolimus ointment 0.1%)
iii. Phototherapy
iv. Oral immunomodulator (azathioprine, cyclosporine, methotrexate, or mycophenolate)
v. Topical PDE-4 (Eucrisa)
3.Diagnosis of ulcerative colitis:
A. Pt has tried and failed a TNF inhibitor
4. Diagnosis of ankylosing spondylitis
A. Pt has tried and failed a TNF inhibitor
5. Is prescriber requesting 45mg dose?
A. If yes, does the patient have UC dx and will only use 45mg dose for a total of 8 weeks? (Please note 45mg dose is only approved for UC and will only be approved for a total of 8 weeks)

Age Restrictions
12 years of age and older

Prescriber Restrictions
Rheumatologist, dermatologist, gastroenterologist or consult

Coverage Duration
Plan Year

Other Criteria
N/A

ROZLYTREK

Drugs
ROZLYTREK

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Pulmonologist

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 BRCA-mutated ovarian cancer
   a. Pt has been treated with at least two prior chemotherapies,
2. Dx of recurrent ovarian cancer
   a. Complete or partial response to platinum-based chemotherapy
3. Rubraca will be used as monotherapy
4. 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
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/27/2022

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
Hematologist or Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

SABRIL

Drugs
VIGABATRIN, VIGADRONE

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

Exclusion Criteria
N/A

Required Medical Information
1. For solution:
   a. Must be used as monotherapy for infantile spasms,
2. For tablets:
   a. Must be used as adjunctive therapy,
   b. Must have tried at least TWO of the following:
      i. Banzel, ii. Carbamazepine, iii. Celontin, iv. Depakene, v. Depakote, vi. Dilantin, vii. Divalproex, viii. Epitol, ix. Equetro, x. Ethosuximide, xi. Felbamate, xii. Gabitril, xiii. Keppra, xiv. Lamictal, xv. Lamotrigine, xvi. Levetiracetam, xvii. Lyrica, xviii. Mysoline, xix. Oxcarbazepine, xx. Peganone, xxi. Phenytoin, xxii. Potiga, xxiii. Stavzor, xxiv. Tegretol, xxv. Topamax, xxvi. Topiramate, xxvii. Trileptal, xxviii. Valproic Acid, xxix. Vimpat, xxx. Zonegran, xxxi. Zonisamide

Age Restrictions
N/A

Prescriber Restrictions
Neurologist

Coverage Duration
Plan Year

Other Criteria
1. Periodic vision testing

Updated 6/27/2022

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

SENSIPAR

Drugs
CINACALCET HYDROCHLORIDE

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

Exclusion Criteria
N/A

Required Medical Information
1. Hypercalcemia associated with HPT dx:
   a. Pt is NOT a candidate for parathyroidectomy

Age Restrictions
18 years old or older

Prescriber Restrictions
Nephrologist, Oncologist, or Endocrinologist

Coverage Duration
Plan Year

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
Endocrinologist

Coverage Duration
Initial: 3 mo,
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
Pulmonologist or Infectious Disease Specialist

Coverage Duration
6 Months

Other Criteria
N/A

SITAVIG

Drugs
SITAVIG

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

SKYRIZI

Drugs
SKYRIZI, SKYRIZI PEN

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

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

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

Age Restrictions
N/A

Prescriber Restrictions
Dermatologist, rheumatologist, or consult

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

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist, Oncologist, or consult

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. For adult chronic, accelerated, myeloid, or blast phase CML dx:
   a. Previous trial on imatinib,
2. For adult ALL dx:
   a. Resistance or intolerance to at least ONE prior therapy,
   b. Efficacy testing will be conducted in accordance with NCCN recommended treatment guidelines,
   c. After failure of treatment per NCCN CML guideline testing patient does NOT have a T315I mutation based BCR-ABL kinase domain testing
3. For adult newly diagnosed Philadelphia positive (Ph+) CML in chronic phase
4. For pediatric ALL dx:
   a. Newly dx Philadelphia positive (Ph+) ALL to be used in combination with chemotherapy
5. For pediatric CML dx:
   a. Ph+ CML in chronic phase

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

Coverage Duration
Plan Year

Updated 6/27/2022

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
Dermatologist, Gastroenterologist, Rheumatologist, or consult

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
Oncologist

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
Gastroenterologist or Metabolic Specialist

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 Gleevec,
2. For pNET dx:
   a. Tumor is unresectable locally advanced or metastatic

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

SYMDEKO

Drugs
SYMDEKO

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

Exclusion Criteria
Pt has history of a transplant

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

Age Restrictions
6 yo and older

Prescriber Restrictions
Pulmonologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/27/2022

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
Endocrinologist or Gynecologist

Coverage Duration
6 Months

Other Criteria
N/A

SYNRIBO

Drugs
SYNRIBO

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

Exclusion Criteria
N/A

Required Medical Information
1. Pt has resistance and/or intolerance to TWO or more of the following:
   a. Gleevec, b. Sprycel, c. Tasigna, d. Bosulif

Age Restrictions
N/A

Prescriber Restrictions
Hematologist or Oncologist

Coverage Duration
Plan Year

Other Criteria
BvsD determination

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 Depen,
2. Pt is receiving oral zinc salts

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
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

TAFINLAR

Drugs
TAFINLAR

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

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

Required Medical Information
1. For Melanoma dx: Pt is BRAF (V600E or V600K) mutation positive
2. For NSCLC dx: Pt is BRAF V600E positive

Age Restrictions
N/A

Prescriber Restrictions
Oncologist, Hematologist, or Dermatologist

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
Oncologist

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. Does the patient have HAE type I or II?
    A. If yes, has the diagnosis of HAE type I or II been verified by low C1-INH and/or low C1-INH functional levels on two separate occasions?
2. Does the patient have a history of 5 or more facial, laryngeal, and/or gastrointestinal HAE attacks per month?
3. Is the patient compliant with trigger avoidance (e.g., avoidance of medications such as ACE-inhibitors and estrogen)?
4. For reauthorization, has the patient had a significant decrease in the frequency of attacks per month (at least 50 percent decrease), 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

TALZENNA

Drugs
TALZENNA

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

Exclusion Criteria
N/A

Required Medical Information
1) Deleterious or suspected deleterious germline BRCA, HER2-negative locally advanced or metastatic breast cancer
2) prior treatment with a taxane and/or anthracycline in the neoadjuvant, adjuvant, locally advanced, or metastatic setting

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

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, TARGRETIN

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
Dermatologist, Hematologist, or Oncologist

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 1.5 g/g
3. eGFR greater than or equal to 35 mL/min/1.73 m2
4. Stable at maximally tolerated dose of RAS therapy

Age Restrictions
18 years of age and older

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
Oncologist or Hematologist

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
Hematologist, Oncologist

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 6/27/2022

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
16 years of age and older

Prescriber Restrictions
Oncologist specializing in epithelioid sarcoma treatment

Coverage Duration
Plan Year

Other Criteria
N/A
Updated 6/27/2022

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
Infectious Disease Specialist

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
18 years old or older

Prescriber Restrictions
Provider that specializes in treatment of hTTAR amyloidosis

Coverage Duration
Initial: 6 months
Reauth: 6 months

Other Criteria
BvsD Determination

Updated 6/27/2022

TEPMETKO

Drugs
TEPMETKO

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

Exclusion Criteria
N/A

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

Age Restrictions
18 years of age and older

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

THIORIDAZINE

Drugs
THIORIDAZINE HCL

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

Exclusion Criteria
N/A

Required Medical Information
1. Previous trial on BOTH of the following:
   a. Fluphenazine, b. Molindone

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

TIBSOVO

Drugs
TIBSOVO

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

Exclusion Criteria
N/A

Required Medical Information
1. AML newly diagnosed is susceptible isocitrate dehydrogenase-1 (IDH1) mutation
2. AML is susceptible isocitrate dehydrogenase-1 (IDH1) mutation and has relapsed or is refractory to one or more prior anticancer regimens

Age Restrictions
N/A

Prescriber Restrictions
Hematologist or Oncologist

Coverage Duration
12 months

Other Criteria
N/A

TRIKAFTA

Drugs
TRIKAFTA

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

Exclusion Criteria
1. Clinically significant cirrhosis

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

Age Restrictions
6 years of age and older

Prescriber Restrictions
Pulmonologist or Consult

Coverage Duration
Initial: 3 months
Reauthorization: 12 months

Other Criteria
N/A

Updated 6/27/2022

TROKENDI

Drugs
TOPIRAMATE ER

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 immediate release topiramate,
2. Pt has previous failure with at least ONE other antiepileptic drug

Age Restrictions
1. Topiramate ER: 2 years old and older

Prescriber Restrictions
Neurologist or consult, headache specialist, or pain specialist

Coverage Duration
Plan Year

Other Criteria
N/A

TRUSELTIQ

Drugs
TRUSELTIQ

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

Exclusion Criteria
N/A

Required Medical Information
Initial
1. Dx of Cholangiocarcinoma, unresectable, locally advanced or mestatic
2. Previously treated for unresectable locally advanced or metastatic cholangiocarcinoma
3. Fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement
Reauthorization:
1. Patient is stable on therapy

Age Restrictions
18 years or older

Prescriber Restrictions
Oncologist or consult

Coverage Duration
12 months

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

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
Oncologist or orthopedic surgeon

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
18 years old or older

Prescriber Restrictions
Infectious Disease Specialist

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

TYMLOS

Drugs
TYMLOS

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

Exclusion Criteria
1. Treatment longer than 24 months

Required Medical Information
1. T-score of less than equal to -2.5,
2. Pt has previous trial or intolerance or contraindication to bisphosphonate therapy (IV or oral),
3. Pt has previous trial on Prolia

Age Restrictions
N/A

Prescriber Restrictions
Endocrinologist, Rheumatologist, Gynecologist, Orthopedist

Coverage Duration
Plan Year

Other Criteria
N/A

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

UKONIQ

Drugs
UKONIQ

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 marginal zone lymphoma
   a. Pt has previous use of ONE prior anti-CD20-based regimen
2. Diagnosis of relapsed or refractory follicular lymphoma
   b. Pt has previous use of THREE prior lines of systemic therapy

Age Restrictions
N/A

Prescriber Restrictions
Hematologist or Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

UPTRAVI

Drugs
UPTRAVI

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

Exclusion Criteria
N/A

Required Medical Information
1. Initial:
   a. If pt has a positive vasoreactivity test:
      i. Pt has failed maximum tolerated doses of calcium channel blockers,
   b. Pt has previous trial on at least ONE of the following:
      i. sildenafil, ii. tadalafil
2. Reauth:
   a. Pt has been reassessed within the past 6 months.

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
6 Months

Other Criteria
N/A

Updated 6/27/2022

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
Oncologist or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

VASODILATORS

Drugs
ORENITRAM, VENTAVIS

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

Exclusion Criteria
N/A

Required Medical Information
1. For NYHA functional class II or III:
   a. Previous trial on at least one of the following:
      i. Adcirca, ii. Letairis, iii. Opsumit, iv. sildenafil, v. Tracleer,
2. Presence of functional class IV

Age Restrictions
N/A

Prescriber Restrictions
Pulmonologist or Cardiologist

Coverage Duration
Plan Year

Other Criteria
BvsD Determination for Ventavis

VELTASSA

Drugs
VELTASSA

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

Exclusion Criteria
N/A

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

Age Restrictions
18 years old or older

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 Months,
Reauth: Plan Year

Other Criteria
N/A

Updated 6/27/2022

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
Gastroenterologist, Infectious Disease Specialist, Transplant Specialist

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
Oncologist, Hematologist, or consult

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
3. Pt has failed prior treatment with sacubitril-valsartan (Entresto) OR the patient has a contraindication or intolerance

Age Restrictions
N/A

Prescriber Restrictions
Cardiologist or in consult with

Coverage Duration
Plan Year

Other Criteria
N/A

VERSACLOZ

Drugs
VERSACLOZ

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

Exclusion Criteria
N/A

Required Medical Information
1. Pt has had an inadequate response to at least TWO antipsychotic medications, a. At least one medication must be a long-acting depot, OR 2. Pt has medical condition that prohibits the use of tablets

Age Restrictions
N/A

Prescriber Restrictions
Psychiatrist

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 and a Ki-67 score greater than or equal to 20%
    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 postmenopausal AND 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
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A

Updated 6/27/2022

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
Oncologist

Coverage Duration
Plan year

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
Oncologist

Coverage Duration
12 months

Other Criteria
N/A

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
Gastroenterologist, Infectious Disease Specialist, or Transplant Specialist

Coverage Duration
12 Weeks

Other Criteria
N/A

VOTRIENT

Drugs
VOTRIENT

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

Exclusion Criteria
N/A

Required Medical Information
1. Soft Tissue Sarcoma dx:
   a. Previous trial on at least ONE prior therapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

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 6/27/2022

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

Age Restrictions
5 years of age and older

Prescriber Restrictions
N/A

Coverage Duration
Initial: 6 months
Reauth: 12 months

Other Criteria
BvD Determination

VYNDAQEL

Drugs
VYNDAMAX, VYNDAQEL

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

Exclusion Criteria
1. Use in combination with Onpattro or Tegsedi

Required Medical Information
I. For cardiomyopathy of hereditary transthyretin-mediated amyloidosis (ATTR-CM)
A. Applicable mutation to the transthyretin (TTR) gene (e.g., Val122Ile, Thr60Ala, or Ile68Leu)
B. Clinical manifestations of amyloid fibrosis in the myocardium (e.g., AV bundle branch block, restrictive cardiomyopathy and heart failure with preserved ejection fraction [HFpEF])
II. For cardiomyopathy of wild type transthyretin-mediated amyloidosis (ATTR-CM)
B. Negative for monoclonal protein in blood or urine (evaluated by serum free light chains and serum protein electrophoresis with urine immunofixation)
C. Absence of monoclonal proteins has the patient undergone nuclear scintigraphy diagnosis OR presence of monoclonal proteins has the patient undergone tissue biopsy to rule out light chain cardiac amyloidosis
D. Clinical manifestations of amyloid fibrosis in the myocardium (e.g., AV bundle branch block, restrictive cardiomyopathy and heart failure with preserved ejection fraction [HFpEF]

Age Restrictions
18 years of age or older

Prescriber Restrictions
Prescriber specializes in the treatment of cardiomyopathy of transthyretin-mediated amyloidosis (ATTR-CM)

Coverage Duration
Plan Year

Other Criteria
N/A

WELIREG

Drugs
WELIREG

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

Exclusion Criteria
1. Requires immediate surgery

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

Age Restrictions
18 years or older

Prescriber Restrictions
Oncologist or consult

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. NSCLC must be ONE of the following:
   a. Anaplastic lymphoma kinase (ALK)-positive,
   b. Reactive oxygen species 1 (ROS1) positive

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

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

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

Age Restrictions
N/A

Prescriber Restrictions
Rheumatologist, Gastroenterologist, or consult

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
Neurologist

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
Oncologist or gastroenterologist

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
Oncologist

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
Gastroenterologist, Infectious Disease Specialist, or Hepatologist

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
N/A

Required Medical Information
1. For asthma dx:
   a. Pt has previous trial (or documented contraindication) of at least ONE of the following for at least 3 months:
      i. Medium dose ICS and inhaled long-acting bronchodilator,
      ii. Medium dose ICS and leukotriene antagonist,
      iii. Medium dose ICS and theophylline,
      iv. High dose ICS and inhaled long-acting bronchodilator,
      v. Low dose ICS and inhaled long-acting bronchodilator,
   b. Pt has had need for frequent intermittent use of oral corticosteroids,
   c. Pt has at least ONE of the following:
      i. ER visit or hospitalization for asthma within past 6 months,
      ii. Need for frequent office visits due to asthma evaluation,
   d. Pt's IgE level is greater than or equal to 30,
      e. Pt is less than 330 lbs,
2. For CIU dx:
   a. Pt has previous failure on a H-1 antagonist,
   b. Pt has required at least one recent course of oral steroids
3. Dx of Nasal Polyps
   A. Previous use of systemic corticosteroid therapy
   B. Will be used as add-on treatment when there has been an inadequate response to nasal corticosteroids
4. Reauthorization for nasal polyps:
   A. reduction in their nasal polyp size and nasal congestion

Age Restrictions
Nasal Polyps: 18 or older

Prescriber Restrictions
Allergist, Pulmonologist, Dermatologist, Immunologist, or ENT

Coverage Duration
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
Oncologist or hematologist

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 four prior therapies
      i. Refractory to at least two proteasome inhibitors
      ii. Refractory to at least two immunomodulatory agents
      iii. Refractory to an anti-CD38 monoclonal antibody
   b. Previous use of one prior therapy
      i. Will be used in combination with bortezomib and dexamethasone
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
Oncologist or hematologist

Coverage Duration
Plan Year

Other Criteria
N/A
Updated 6/27/2022

XTANDI

Drugs
XTANDI

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

Exclusion Criteria
N/A

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

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Urologist

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
Medical Geneticist or Metabolic Specialist

Coverage Duration
Plan Year

Other Criteria
N/A

XYREM

Drugs
XYREM, XYWAV

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

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

Required Medical Information
1. Initial:
   a. For narcolepsy without cataplexy:
      i. exhibits symptoms of excessive daytime sleepiness
      ii. intolerant to at least one stimulant,
      iii. inadequate response to maximum recommended dose of modafinil or armodafinil, intolerant or allergy to modafinil and armodafinil, or pt is 17 years of age or less,
   b. For narcolepsy with cataplexy:
      i. exhibits symptoms of cataplexy,
      c. For Xywav: For idiopathic hypersomnia
         i. Documented diagnosis of idiopathic hypersomnia by polysomnography and MSLT
         ii. obstructive sleep apnea and narcolepsy have been excluded
         iii. Trial and failure of at least two stimulants (e.g. amphetamine salts, methylphenidate, etc)
2. Reauth:
   a. For narcolepsy: i. Decrease in daytime sleepiness,
   b. For narcolepsy with cataplexy: i. Decrease in cataplexy episodes
      c. For idiopathic hypersomnia: i. Decrease in daytime sleepiness,

Age Restrictions
7 years old or older

Prescriber Restrictions
Board certified in Sleep, Pulmonology, or Neurology

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
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

ZARXIO

Drugs
NEUPOGEN, NIVESTYM, 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 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

ZAVESCA

Drugs
MIGLUSTAT

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

Exclusion Criteria
N/A

Required Medical Information
1. Pt was diagnosed by a Geneticist or consult
2. Pt is unable to use intravenous enzyme replacement

Age Restrictions
N/A

Prescriber Restrictions
N/A

Coverage Duration
Plan Year

Other Criteria
N/A

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. Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer
   a. Complete or partial response to platinum-based chemotherapy
3. Advanced ovarian, fallopian tube, or primary peritoneal cancer
   a. Previously treated with three or more prior chemotherapy regimens
   b. Cancer associated with homologous recombination deficiency (HRD) positive status by one of:
      i. deleterious or suspected deleterious BRCA mutation
      ii. genomic instability and has progressed more than six months after response to the last platinum-based chemotherapy

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

Coverage Duration
Plan Year

Other Criteria
N/A
Updated 6/27/2022

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
Oncologist, Hematologist, or Dermatologist

Coverage Duration
Plan Year

Other Criteria
N/A

ZEPOSIA

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

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

Exclusion Criteria
Combination therapy with a TNF antagonist

Required Medical Information
1. Diagnosis of ulcerative colitis
   A. Patient has failed treatment with at least two of the following: Entyvio, Humira, Renflexis, Stelara, Rinvoq
2. For Dx of CIS, RRMS or aSPMS
   A. Has a differential diagnosis of neuroinflammatory disease, such as neuromyelitis optica (NMO), been excluded?
   B. Failure of one of the following generic medications (dimethyl fumarate, glatiramer acetate, or Glatopa)
   C. Was the patient diagnosis of multiple sclerosis supported by the 2017 McDonald diagnostic criteria (Please select the appropriate diagnostic finding below based on number of attacks, number of lesions, and additional clinical data needed)?
      i. Two attacks PLUS two lesions on MRI.
      ii. Two attacks, one lesion, and evidence of dissemination in space on MRI.
      iii. One attack, two lesions, and evidence of dissemination in time on MRI
      iv. One attack, one lesion, and evidence of dissmenation in space AND time on MRI. OR demonstration of CSF-specific oligoclonal bands.
      v. One attack, one lesion, and evidence of dissmenation in space on MRI AND demonstration of CSF-specific oligoclonal bands.
   D. For new starts only, have the MRI findings been reviewed and interpreted by a radiologist to confirm the diagnosis and findings? Please note, MRI and radiologist interpretation must be submitted.

Age Restrictions
N/A

Prescriber Restrictions
N/A

Updated 6/27/2022

Coverage Duration
12 months

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

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 Rituxan,
2. Non-Hodgkin dx:
   a. Pt has failure of two prior systemic therapies,
3. Small Lymphocytic Lymphoma dx:
   a. Pt has failure of two prior systemic therapies

Age Restrictions
N/A

Prescriber Restrictions
Oncologist or Hematologist

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. Pt has previous trial on Xalkori

Age Restrictions
N/A

Prescriber Restrictions
Oncologist

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
Oncologist or Urologist

Coverage Duration
Plan Year

Other Criteria
N/A

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