

WyoBLUE ADVANTAGE

An independent licensee of the Blue Cross Blue Shield Association

WyoBlue Advantage PPO
Comprehensive Formulary
Prior Authorization / Step Therapy Program
2026 Plan Year
Updated 11/01/2026

WyoBlue Advantage monitors the use of certain medications to ensure our members receive the most appropriate and cost-effective drug therapy. **Prior authorization (PA)** for these drugs means that either clinical and/or administrative criteria must be met before coverage is provided. Drugs subject to **step therapy (ST)** may require previous treatment with one or more formulary drugs prior to coverage. Drugs that must meet clinical/administrative criteria are identified in the formulary list with (PA) or (ST). In some cases, the brand name drug is listed for reference and the generic drug is covered. Please refer to the Formulary to verify if your drugs are covered. Your physician can contact our pharmacy help desk to request prior authorization or step therapy for these drugs.

The clinical criteria for authorization are based on current medical information and the recommendations of the Pharmacy Benefit Manager's Pharmacy and Therapeutics Committee, a group of physicians, pharmacists, and other experts.

Please call the pharmacy service number on the back of your WyoBlue Advantage member ID card if you have questions about your drug coverage or a drug claim.

ACITRETIN

Products Affected

- Acitretin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ACTIMMUNE

Products Affected

- Actimmune INJ 100MCG/0.5ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ADBRY

Products Affected

- Adbry

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	N/A
Age Restrictions	AT LEAST 12 YEARS OF AGE
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR ATOPIC DERMATITIS (AD) FOR PATIENTS 12 YEARS OF AGE AND OLDER REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS AND A TRIAL AND TREATMENT FAILURE OF ONE OF THE FOLLOWING: HIGH POTENCY TOPICAL CORTICOSTEROID, TACROLIMUS, PIMECROLIMUS, CYCLOSPORINE, AZATHIOPRINE OR MYCOPHENOLATE MOFETIL. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY. FOR PATIENTS WEIGHING LESS THAN 100 KG WHO ACHIEVE POSITIVE CLINICAL RESPONSE AFTER 16 WEEKS OF TREATMENT, DOSAGE IS LIMITED TO 300 MG EVERY 4 WEEKS OR CLINICAL RATIONALE IS PROVIDED SUPPORTING CONTINUATION OF INJECTIONS EVERY TWO WEEKS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AFINITOR

Products Affected

- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG
- Torpenz
- Yulithira

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ADVANCED HORMONE RECEPTOR-POSITIVE, HER2-NEGATIVE BREAST CANCER REQUIRES COMBINATION USE WITH EXEMESTANE AND A TRIAL OF LETROZOLE OR ANASTROZOLE. COVERAGE FOR THE TREATMENT OF ADVANCED RENAL CELL CARCINOMA (RCC) REQUIRES A TRIAL OF SUNITINIB OR SORAFENIB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AFINITOR DISPERZ

Products Affected

- Everolimus TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AKEEGA

Products Affected

- Akeega

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS BRCA-MUTATED (BRCAM) METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC) REQUIRES COMBINATION USE WITH PREDNISONE. COVERAGE FOR THE TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS BRCA2-MUTATED (BRCA2M) METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC) REQUIRES COMBINATION USE WITH PREDNISONE.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALOSETRON

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALPHA-1-PROTEINASE INHIBITORS

Products Affected

- Prolastin-c INJ 1000MG/20ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PATIENTS MUST HAVE A DIAGNOSIS OF NECROTIZING PANNICULITIS OR ALPHA-1 ANTITRYPSIN DEFICIENCY WITH AN FEV1 LESS THAN 80% PREDICTED.
Age Restrictions	PATIENTS 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	DOCUMENTATION OF A CONGENITAL DEFICIENCY OF ALPHA-1 ANTITRYPSIN CONSISTENT WITH PHENOTYPES PIZZ, PIZ (NULL), OR PI (NULL, NULL) OF AAT, AND MUST HAVE SYMPTOMATIC EMPHYSEMA.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ANAPLASTIC LYMPHOMA KINASE (ALK)-POSITIVE METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES A TRIAL OF CRIZOTINIB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF RECURRENT PERICARDITIS REQUIRES A TRIAL OF A NONSTEROIDAL ANTI-INFLAMMATORY DRUG IN COMBINATION WITH COLCHICINE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AUBAGIO

Products Affected

- Teriflunomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AUGTYRO

Products Affected

- Augtyro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AUVELITY

Products Affected

- Auvelity
- Auvelity Titration Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	COVERAGE FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER REQUIRES A TRIAL OF BUPROPION AND ONE OTHER GENERIC FORMULARY ANTIDEPRESSANT
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

AVMAPKI FAKZYNJA

Products Affected

- Avmapki Fakzynja Co-pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF LOCALLY ADVANCED OR METASTATIC UROTHELIAL CARCINOMA (MUC) WITH SUSCEPTIBLE FGFR3 GENETIC ALTERATIONS REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BANZEL

Products Affected

- Rufinamide SUSP 40MG/ML
- Rufinamide TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE TRIAL OF DIVALPROEX OR VALPROIC ACID, AND LAMOTRIGINE
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BENLYSTA

Products Affected

- Benlysta INJ 200MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BEQALZI

Products Affected

- Beqalzi
- Beqalzi Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PLAN YEAR
Other Criteria	COVERAGE FOR TREATMENT OF RELAPSED OR REFRACTORY MANTLE CELL LYMPHOMA REQUIRES A TRIAL OF AT LEAST TWO LINES OF SYSTEMIC THERAPY, INCLUDING A BRUTON'S TYROSINE KINASE (BTK) INHIBITOR.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BESREMI

Products Affected

- Besremi
- Besremi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT OF POLYCYTHEMIA VERA REQUIRES TRIAL OF HYDROXYUREA. COVERAGE FOR TREATMENT OF ESSENTIAL THROMBOCYTHEMIA REQUIRES TRIAL OF HYDROXYUREA.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BETASERON

Products Affected

- Betaseron

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BOSULIF

Products Affected

- Bosulif CAPS
- Bosulif TABS 100MG, 500MG
- Bosutinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ACCELERATED, OR BLAST PHASE PH+ CML REQUIRES A TRIAL OF PRIOR THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRAFTOVI

Products Affected

- Braftovi CAPS 75MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH BINIMETINIB. COVERAGE FOR THE INITIAL TREATMENT OF METASTATIC COLORECTAL CANCER (CRC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH CETUXIMAB AND FLUOROURACIL-BASED CHEMOTHERAPY. COVERAGE FOR THE TREATMENT OF METASTATIC COLORECTAL CANCER (CRC) WITH A BRAF V600E MUTATION AFTER PRIOR THERAPY REQUIRES COMBINATION USE WITH CETUXIMAB. COVERAGE FOR THE TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH BINIMETINIB.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRIVIACT

Products Affected

- Brivaracetam SOLN
- Brivaracetam TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES TRIAL OF LEVETIRACETAM AND ONE OTHER FORMULARY GENERIC ANTICONVULSANT
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF MANTLE CELL LYMPHOMA (MCL) REQUIRES A TRIAL OF CALQUENCE. COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY MARGINAL ZONE LYMPHOMA (MZL) REQUIRES A TRIAL OF AT LEAST ONE ANTI-CD20- BASED REGIMEN. COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY FOLLICULAR LYMPHOMA (FL) REQUIRES COMBINATION USE WITH OBINUTUZUMAB AND A TRIAL OF TWO OR MORE LINES OF SYSTEMIC THERAPY. COVERAGE FOR THE TREATMENT OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) OR SMALL LYMPHOCYTIC LYMPHOMA (SLL) REQUIRES A TRIAL OF CALQUENCE OR IMBRUVICA.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

BUDESONIDE

Products Affected

- Budesonide Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	COVERAGE WILL NOT BE PROVIDED FOR MAINTENANCE OF REMISSION IN ULCERATIVE COLITIS.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MONTHS
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

BYSANTI

Products Affected

- Bysanti
- Bysanti Titration Pack A
- Bysanti Titration Pack B
- Bysanti Titration Pack C

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PLAN YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA IN ADULT PATIENTS REQUIRES THE TRIAL OF LURASIDONE AND PALIPERIDONE. FOR ALL OTHER INDICATIONS, COVERAGE REQUIRES THE TRIAL OF AT LEAST TWO OF THE FOLLOWING GENERIC DRUGS: ARIPIPRAZOLE, ASENAPINE, LURASIDONE, OLANZAPINE, PALIPERIDONE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR FIRST-LINE TREATMENT OF ADVANCED RENAL CELL CARCINOMA REQUIRES COMBINATION USE WITH NIVOLUMAB. COVERAGE FOR THE TREATMENT OF HEPATOCELLULAR CARCINOMA (HCC) REQUIRES A TRIAL OF SORAFENIB. COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC DIFFERENTIATED THYROID CANCER (DTC) THAT IS RADIOACTIVE IODINE-REFRACTORY OR INELIGIBLE REQUIRES A TRIAL OF VEGFR-TARGETED THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CALCIPOTRIENE

Products Affected

- Calcipotriene CREA
- Calcipotriene SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	REQUIRES TRIAL OF AT LEAST ONE GENERIC TOPICAL STEROID.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CALQUENCE

Products Affected

- Calquence TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	ONE YEAR
Other Criteria	COVERAGE FOR MANTLE CELL LYMPHOMA (MCL) REQUIRES THAT THE PATIENT HAS RECEIVED AT LEAST ONE PRIOR THERAPY FOR THE TREATMENT OF MCL. COVERAGE FOR PREVIOUSLY UNTREATED MCL IN PATIENTS WHO ARE INELIGIBLE FOR AUTOLOGOUS HEMATOPOIETIC STEM CELL TRANSPLANTATION (HSCT) REQUIRES COMBINATION USE WITH BENDAMUSTINE AND RITUXIMAB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CAVHANZA

Products Affected

- Cavhanza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PLAN YEAR
Other Criteria	COVERAGE FOR ADULT PATIENTS WITH CHRONIC PHASE (CP) CML NOT NEWLY DIAGNOSED AND ACCELERATED PHASE (AP) PH+ CML REQUIRES A TRIAL OF PRIOR THERAPY THAT INCLUDED IMATINIB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CIALIS

Products Affected

- Tadalafil TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	COVERAGE IS NOT PROVIDED FOR TADALAFIL IN SITUATIONS WHERE PATIENTS ARE RECEIVING NITRATE THERAPY.
Required Medical Information	REQUIRES THE DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CLOMIPHENE

Products Affected

- Clomid
- Clomiphene Citrate TABS
- Milophene

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COBENFY

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA REQUIRES A TRIAL OF AT LEAST TWO SECOND GENERATION ANTIPSYCHOTICS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COPAXONE

Products Affected

- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF RELAPSED OR REFRACTORY CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) OR SMALL LYMPHOCYTIC LYMPHOMA (SLL) REQUIRES A TRIAL OF AT LEAST TWO PRIOR THERAPIES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COSENTYX

Products Affected

- Cosentyx INJ 150MG/ML, 75MG/0.5ML
- Cosentyx Sensoready Pen
- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF CHRONIC MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (AXSPA) REQUIRES A DIAGNOSIS OF NON-RADIOGRAPHIC AXSPA AND OBJECTIVE SIGNS OF INFLAMMATION. COVERAGE FOR NON-RADIOGRAPHIC AXSPA ALSO REQUIRES THE TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR ENTHESITIS-RELATED ARTHRITIS (ERA) REQUIRES A DIAGNOSIS OF ACTIVE ERA AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR HIDRADENITIS SUPPURATIVA (HS) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE HS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH VEMURAFENIB.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CRESEMBA

Products Affected

- Cresemba CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DALFAMPRIDINE

Products Affected

- Dalfampridine Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	EXCLUDED FOR USE IF PATIENT IS WHEEL-CHAIR BOUND OR BECOMES WHEEL-CHAIR BOUND
Required Medical Information	SUBMISSION OF TIMED 25-FOOT WALK TEST
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF MULTIPLE SCLEROSIS (MS) REQUIRES DOCUMENTATION OF A BASELINE TIMED 25-FOOT WALK (T25FW) TEST PRIOR TO INITIATION. REAUTHORIZATION REQUIRES DOCUMENTATION OF STABILITY ON T25FW TEST OR IMPROVEMENT ON T25FW TEST
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) REQUIRES COMBINATION USE WITH LOW-DOSE CYTARABINE.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS. COVERAGE FOR THE TREATMENT OF SEIZURES ASSOCIATED WITH DRAVET SYNDROME REQUIRES COMBINATION USE WITH CLOBAZAM.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DIHYDROERGOTAMINE NASAL SPRAY

Products Affected

- Dihydroergotamine Mesylate SOLN

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES TRIAL OF TWO TRIPTANS ON THE FORMULARY: ONE ORAL TRIPTAN AND ONE NON-ORAL TRIPTAN (SUCH AS NASAL SPRAY OR INJECTION).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DRIZALMA SPRINKLE

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

DULERA

Products Affected

- Dulera

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR ASTHMA REQUIRES A DIAGNOSIS OF ASTHMA AND TRIAL OF ONE OF THE FOLLOWING: 1. BREO ELLIPTA OR 2. ADVAIR HFA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

DUPIXENT

Products Affected

- Dupixent INJ 200MG/1.14ML, 300MG/2ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	EOE: PATIENT MUST WEIGH AT LEAST 15 KILOGRAMS
Age Restrictions	AD: AT LEAST 6 MONTHS OF AGE. EA, CDA: AT LEAST 6 YEARS OF AGE. EOE: AT LEAST 1 YEAR OF AGE. PN: AT LEAST 18 YEARS OF AGE. CRSWNP: AT LEAST 12 YEARS OF AGE, CSU: AT LEAST 2 YEARS OF AGE.
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR ATOPIC DERMATITIS (AD) FOR PATIENTS 2 YEARS OF AGE AND OLDER REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS AND A TRIAL AND TREATMENT FAILURE OF ONE OF THE FOLLOWING: HIGH POTENCY TOPICAL CORTICOSTEROID, TACROLIMUS, PIMECROLIMUS, CYCLOSPORINE, AZATHIOPRINE OR MYCOPHENOLATE MOFETIL. COVERAGE FOR EOSINOPHILIC ASTHMA (EA) REQUIRES DIAGNOSIS OF EA WITH EOSINOPHIL COUNT OF AT LEAST 150 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR CORTICOSTEROID DEPENDENT ASTHMA (CDA) REQUIRES DIAGNOSIS OF MODERATE TO SEVERE ASTHMA, CURRENTLY DEPENDENT ON ORAL CORTICOSTEROIDS. COVERAGE FOR EA AND CDA ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). COVERAGE FOR EOSINOPHILIC ESOPHAGITIS (EOE) REQUIRES DIAGNOSIS OF SYMPTOMATIC EOE AND TRIAL OF EITHER 1) A PROTON PUMP INHIBITOR (E.G., PANTOPRAZOLE, OMEPRAZOLE) OR 2) TOPICAL (ESOPHAGEAL) CORTICOSTEROIDS (E.G., INHALED BUDESONIDE, INHALED FLUTICASONE). COVERAGE FOR PRURIGO NODULARIS (PN) REQUIRES DIAGNOSIS OF PN. COVERAGE FOR ADD-ON MAINTENANCE TREATMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) REQUIRES A DIAGNOSIS OF UNCONTROLLED, MODERATE TO SEVERE COPD AND AN EOSINOPHIL COUNT OF GREATER THAN OR EQUAL TO 300 CELLS PER MICROLITER. COVERAGE FOR COPD ALSO REQUIRES THAT THE PATIENT IS CURRENTLY RECEIVING AND WILL CONTINUE TO RECEIVE THE FOLLOWING, UNLESS CONTRAINDICATED: A LONG-ACTING BETA-2 AGONST (LABA, E.G. SALMETEROL), A LONG-ACTING MUSCARINIC ANTAGONIST (LAMA, E.G., TIOTROPIUM), AND

Other Criteria	AN INHALED CORTICOSTEROID (E.G., FLUTICASONE). COVERAGE FOR CHRONIC SPONTANEOUS URTICARIA (CSU) REQUIRES DIAGNOSIS OF CSU AND SYMPTOMS DESPITE H1 ANTIHISTAMINE TREATMENT. COVERAGE FOR CSU ALSO REQUIRES A TRIAL OF AT LEAST ONE SECOND GENERATION ANTIHISTAMINE. COVERAGE FOR ALLERGIC FUNGAL RHINOSINUSITIS (AFRS) REQUIRES A DIAGNOSIS OF AFRS AND A HISTORY OF SINO-NASAL SURGERY. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EBGLYSS

Products Affected

- Ebglyss

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	PATIENT MUST WEIGH AT LEAST 40 KILOGRAMS
Age Restrictions	AT LEAST 12 YEARS OF AGE
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR ATOPIC DERMATITIS (AD) FOR PATIENTS 12 YEARS OF AGE AND OLDER REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS AND A TRIAL AND TREATMENT FAILURE OF ONE OF THE FOLLOWING: HIGH POTENCY TOPICAL CORTICOSTEROID, TACROLIMUS, PIMECROLIMUS, CYCLOSPORINE, AZATHIOPRINE OR MYCOPHENOLATE MOFETIL. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EMGALITY

Products Affected

- Emgality

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES TRIAL WITH TWO OF THE FOLLOWING: MARPLAN, PHENELZINE, TRANYLCYPROMINE
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENBREL

Products Affected

- Enbrel INJ 25MG/0.5ML, 50MG/ML
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR JUVENILE PSORIATIC ARTHRITIS (JPSA) REQUIRES A DIAGNOSIS OF ACTIVE JPSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENDARI

Products Affected

- L-glutamine PACK

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	PATIENT HAS EXPERIENCED 2 OR MORE SICKLE CELL-RELATED CRISES IN THE PAST 12 MONTHS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	REQUIRES THE TRIAL OF OR INTOLERANCE TO HYDROXYUREA.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ENSACOVE

Products Affected

- Ensacove

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR A DIAGNOSIS OF LENNOX-GASTAUT SYNDROME REQUIRES A TRIAL OF 2 GENERIC ALTERNATIVES FOR THE TREATMENT OF SEIZURES. COVERAGE FOR A DIAGNOSIS OF DRAVET SYNDROME REQUIRES A TRIAL OF 2 OF THE FOLLOWING: VALPROIC ACID, CLOBAZAM, OR TOPIRAMATE. COVERAGE FOR TREATMENT OF SEIZURES ASSOCIATED WITH TUBEROUS SCLEROSIS COMPLEX REQUIRES A TRIAL OF 2 GENERIC ALTERNATIVES FOR THE TREATMENT OF SEIZURES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EPRONTIA

Products Affected

- Topiramate SOLN 25MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE PREVENTATIVE TREATMENT OF MIGRAINE REQUIRES THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ALTERNATIVES FOR MIGRAINE PREVENTION, OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES. COVERAGE FOR THE TREATMENT OF SEIZURE DISORDER/EPILEPSY REQUIRES THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ANTICONVULSANTS, OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBING PHYSICIAN IS AN ONCOLOGIST OR DERMATOLOGIST
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ERYTHROPOIESIS STIMULATING AGENTS

Products Affected

- Procrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	ERYTHROPOIESIS STIMULATING AGENTS ARE SUBJECT TO PART B VS PART D REVIEW.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ESBRIET

Products Affected

- Pirfenidone CAPS
- Pirfenidone TABS 267MG, 801MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

EUCRISA

Products Affected

- Eucrisa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR.
Other Criteria	COVERAGE FOR ATOPIC DERMATITIS REQUIRES A TRIAL OF ONE OF THE FOLLOWING: A TOPICAL STEROID, GENERIC PROTOPIC, OR GENERIC ELIDEL.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

EULEXIN

Products Affected

- Eulexin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES A TRIAL OF GENERIC BICALUTAMIDE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FANAPT

Products Affected

- Fanapt
- Fanapt Titration Pack A
- Fanapt Titration Pack B
- Fanapt Titration Pack C

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA REQUIRES A TRIAL OF TWO GENERIC FORMULARY ATYPICAL ANTIPSYCHOTICS (E.G., ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE)
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	EGPA: COVERAGE REQUIRES TWO OF THE FOLLOWING CRITERIA THAT ARE TYPICAL OF EGPA: 1) HISTOPATHOLOGICAL EVIDENCE OF EOSINOPHILIC VASCULITIS, PERIVASCULAR EOSINOPHILIC INFILTRATION, OR EOSINOPHIL-RICH GRANULOMATOUS INFLAMMATION, 2) NEUROPATHY, 3) PULMONARY INFILTRATES, 4) ALLERGIC RHINITIS AND NASAL POLYPS, 5) CARDIOMYOPATHY, 6) GLOMERULONEPHRITIS, 7) ALVEOLAR HEMORRHAGE, 8) PALPABLE PURPURA, 9) ANTINEUTROPHIL CYTOPLASMIC ANTIBODY (ANCA) POSITIVITY.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR EOSINOPHILIC ASTHMA (EA) REQUIRES DIAGNOSIS OF EA WITH EOSINOPHIL COUNT OF AT LEAST 150 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR EA ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) REQUIRES A DIAGNOSIS OF EGPA AND HISTORY OR PRESENCE OF ASTHMA. COVERAGE FOR HYPEREOSINOPHILIC SYNDROME (HES) REQUIRES DIAGNOSIS OF HES AND EOSINOPHIL COUNT OF AT LEAST 1000 CELLS PER MICROLITER AT INITIATION OF TREATMENT. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FETZIMA

Products Affected

- Fetzima
- Fetzima Titration Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	COVERAGE FOR THE TREATMENT OF MAJOR DEPRESSIVE DISORDER REQUIRES A TRIAL OF VENLAFAXINE (OR DESVENLAFAXINE) AND DULOXETINE
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE TRIAL OF TWO OF THE FOLLOWING: VALPROIC ACID, CLOBAZAM, TOPIRAMATE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FIRAZYR

Products Affected

- Icatibant Acetate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR ADVANCED RENAL CELL CARCINOMA REQUIRES A TRIAL OF TWO OR MORE PRIOR SYSTEMIC THERAPIES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FRUZAQLA

Products Affected

- Fruzaqla

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR METASTATIC COLORECTAL CANCER (mCRC) REQUIRES A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, IRINOTECAN-BASED CHEMOTHERAPY, AND AN ANTI-VEGF THERAPY. COVERAGE FOR THE TREATMENT OF RAS WILD-TYPE METASTATIC COLORECTAL CANCER ALSO REQUIRES TRIAL OF AN ANTI-EGFR THERAPY
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

FULPHILA

Products Affected

- Fulphila

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

FYCOMPA

Products Affected

- Fycompa
- Perampanel

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR ADVANCED OR METASTATIC RET FUSION-POSITIVE THYROID CANCER THAT REQUIRES SYSTEMIC THERAPY AND RADIOACTIVE IODINE-REFRACTORY (IF RADIOACTIVE IODINE IS APPROPRIATE).
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GILENYA

Products Affected

- Fingolimod Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE WILL BE PROVIDED AS FIRST-LINE TREATMENT OF PATIENTS WITH METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WHOSE TUMORS HAVE NON-RESISTANT EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) MUTATIONS AS DETECTED BY AN FDA-APPROVED TEST, AND FOR PATIENTS WITH METASTATIC NSCLC PROGRESSING AFTER PLATINUM-BASED CHEMOTHERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

GLP-1 AGONISTS

Products Affected

- Mounjaro
- Ozempic INJ 2MG/3ML, 4MG/3ML, 8MG/3ML
- Ozempic TABS
- Rybelsus TABS 14MG, 3MG, 7MG
- Trulicity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	EXCLUDED IF USED FOR THE TREATMENT OF WEIGHT LOSS ONLY.
Required Medical Information	ONE OF THE FOLLOWING: A) FOR PATIENTS REQUIRING ONGOING TREATMENT FOR TYPE 2 DIABETES MELLITUS (T2DM), SUBMISSION OF MEDICAL RECORDS (E.G., CHART NOTES) CONFIRMING DIAGNOSIS OF T2DM, OR B) SUBMISSION OF MEDICAL RECORDS (E.G., CHART NOTES) CONFIRMING DIAGNOSIS OF T2DM AS EVIDENCED BY ONE OF THE FOLLOWING LABORATORY VALUES: I) A1C GREATER THAN OR EQUAL TO 6.5%, II) FASTING PLASMA GLUCOSE (FPG) GREATER THAN OR EQUAL TO 126 MG/DL, OR III) 2-HOUR PLASMA GLUCOSE (PG) GREATER THAN OR EQUAL TO 200 MG/DL DURING OGTT (ORAL GLUCOSE TOLERANCE TEST).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GOMEKLI

Products Affected

- Gomekli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GRASTEK

Products Affected

- Grastek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

GROWTH HORMONE

Products Affected

- Genotropin
- Genotropin Miniquick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PEDIATRICS EQUALS ONE YEAR. ADULTS EQUALS LIFETIME.
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	6 YEARS OF AGE AND OLDER.
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HERNEXEOS

Products Affected

- Hernexeos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HETLIOZ

Products Affected

- Tasimelteon

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HUMIRA

Products Affected

- Adalimumab-aaty 1-pen Kit INJ 80MG/0.8ML
- Adalimumab-aaty 2-pen Kit
- Adalimumab-aaty 2-syringe
- Adalimumab-aaty Cd/uc/hs Starter
- Adalimumab-adbm
- Adalimumab-adbm Crohns/uc/hs Starter
- Adalimumab-adbm Psoriasis/uveitis Starter
- Adalimumab-adbm Starter Package For Crohns Disease/uc/hs
- Adalimumab-adbm Starter Package For Psoriasis/uveitis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD. COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC. COVERAGE FOR HIDRADENITIS SUPPURATIVA (HS) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE HS. COVERAGE FOR UVEITIS REQUIRES A DIAGNOSIS OF NON-INFECTIOUS UVEITIS CLASSIFIED AS ONE OF THE FOLLOWING: INTERMEDIATE, POSTERIOR, PANUVEITIS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

HUMULIN R U-500

Products Affected

- Humulin R U-500 (concentrated)
- Humulin R U-500 Kwikpen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

HYRNUO

Products Affected

- Hyrnuo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH AROMATASE INHIBITOR AS INITIAL ENDOCRINE-BASED THERAPY OR FULVESTRANT IN PATIENTS WITH DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY. COVERAGE FOR THE TREATMENT OF ENDOCRINE-RESISTANT, PIK3CA-MUTATED, HR-POSITIVE, HER2-NEGATIVE, LOCALLY ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH INAVOLISIB AND FULVESTRANT FOLLOWING RECURRENCE ON OR AFTER COMPLETING ADJUVANT ENDOCRINE THERAPY. COVERAGE FOR THE MAINTENANCE TREATMENT OF HR-POSITIVE, HER2-POSITIVE LOCALLY ADVANCED OR METASTATIC BREAST CANCER FOLLOWING INDUCTION TREATMENT REQUIRES COMBINATION USE WITH TRASTUZUMAB, WITH OR WITHOUT PERTUZUMAB, AND ENDOCRINE THERAPY.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IBTROZI

Products Affected

- Ibtrozi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF NEWLY DIAGNOSED PHILADELPHIA CHROMOSOME-POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA (PH+ ALL) REQUIRES COMBINATION USE WITH CHEMOTHERAPY. COVERAGE IS PROVIDED AS MONOTHERAPY FOR THE TREATMENT OF T315I-POSITIVE PH+ ALL WHEN NO OTHER KINASE INHIBIORS ARE INDICATED. COVERAGE IS PROVIDED FOR THE TREATMENT OF T315I-POSITIVE CML (CHRONIC PHASE, ACCELERATED PHASE, OR BLAST PHASE). COVERAGE IS PROVIDED FOR THE TREATMENT OF ACCELERATED PHASE OR BLAST PHASE CML WHEN NO OTHER KINASE INHIBITORS ARE INDICATED. COVERAGE FOR THE TREATMENT OF ALL OTHER CHRONIC PHASE (CP) CHRONIC MYELOID LEUKEMIA (CML) INDICATIONS REQUIRES THE TRIAL AT LEAST TWO PRIOR KINASE INHIBITORS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IMBRUVICA

Products Affected

- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 140MG, 280MG, 420MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR TREATMENT OF CHRONIC GRAFT VERSUS HOST DISEASE REQUIRE A TRIAL OF ONE OR MORE LINES OF SYSTEMIC THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IMKELDI

Products Affected

- Imkeldi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR ALL INDICATIONS REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION OR IS UNABLE TO ACHIEVE PRESCRIBED DOSE WITH TABLET FORMULATION. COVERAGE FOR A DIAGNOSIS OF PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA (PH+ CML) IN BLAST CRISIS (BC), ACCELERATED PHASE (AP), OR IN CHRONIC PHASE (CP) REQUIRES FAILURE OF INTERFERON-ALPHA THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

IMMUNE GLOBULIN (IVIG) PRODUCTS

Products Affected

- Bivigam INJ 10%, 5GM/50ML
- Flebogamma Dif INJ 10GM/200ML, 20GM/400ML, 5GM/100ML
- Gamunex-c

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	IMMUNE GLOBULIN (IVIG) PRODUCTS ARE SUBJECT TO PART B VS PART D REVIEW.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

INLURIYO

Products Affected

- Inluriyo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE WHEN USED AS MONOTHERAPY OR IN COMBINATION WITH ABEMACICLIB FOR THE TREATMENT OF ADULTS WITH ER-POSITIVE, HER2-NEGATIVE, ESR1-MUTATED ADVANCED OR METASTATIC BREAST CANCER WITH DISEASE PROGRESSION REQUIRES TRIAL OF AT LEAST ONE LINE OF ENDOCRINE THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR FIRST-LINE TREATMENT OF ADVANCED RENAL CELL CARCINOMA (RCC) REQUIRE COMBINATION USE WITH AVELUMAB OR PEMBROLIZUMAB. COVERAGE FOR TREATMENT OF ADVANCED CELL CARCINOMA (RCC) REQUIRES A TRIAL OF ONE PRIOR SYSTEMIC THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES TRIAL WITH AZACITIDINE
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IRESSA

Products Affected

- Gefitinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ISOTRETINOIN

Products Affected

- Accutane
- Amnesteem
- Claravis
- Isotretinoin CAPS
- Zenatane

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE TRIAL OF EITHER AN ORAL ANTIBIOTIC OR A BENZOYL PEROXIDE CONTAINING TOPICAL THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ITOVEBI

Products Affected

- Itovebi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF ENDOCRINE-RESISTANT, PIK3CA-MUTATED, HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, LOCALLY ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH PALBOCICLIB AND FULVESTRANT.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IVERMECTIN

Products Affected

- Ivermectin TABS 3MG

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

IWILFIN

Products Affected

- Iwilfin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF HIGH-RISK NEUROBLASTOMA (HRNB) WHO HAVE DEMONSTRATED AT LEAST A PARTIAL RESPONSE TO PRIOR MULITAGENT, MULTIMODALITY THERAPY INCLUDING ANTI-GD2 IMMUNOTHERAPY.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JADENU

Products Affected

- Deferasirox TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

JAKAFI

Products Affected

- Jakafi
- Jakafi Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT OF POLYCYTHEMIA VERA THAT DEMONSTRATED AN INADEQUATE RESPONSE OR ARE INTOLERANT TO HYDROXYUREA. COVERAGE FOR THE TREATMENT OF CHRONIC VERSUS HOST DISEASE REQUIRES A TRIAL OF ONE OR TWO LINES OF SYSTEMIC THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JAYPIRCA

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR MANTLE CELL LYMPHOMA (MCL) REQUIRES A TRIAL OF TWO LINES OF SYSTEMIC THERAPY (INCLUDING A BTK INHIBITOR). COVERAGE FOR RELAPSED OR REFRACTORY CHRONIC LYMPHOCYTIC LEUKEMIA OR SMALL LYMPHOCYTIC LYMPHOMA (CLL/SLL) REQUIRES PRIOR TREATMENT WITH A COVALENT BTK INHIBITOR.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JIDEYTRO

Products Affected

- Jideytro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	COVERAGE FOR LOCALLY ADVANCED OR METASTATIC ROS1-POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES PRIOR TREATMENT WITH A ROS1 KINASE INHIBITOR.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JYLAMVO

Products Affected

- Jylamvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES A TRIAL OF METHOTREXATE TABLET, OR PATIENT HAS A DOCUMENTED DIFFICULTY WITH THE USE OF ORAL TABLET FORMULATION OF METHOTREXATE
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

JYNARQUE

Products Affected

- Tolvaptan TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KERENDIA

Products Affected

- Kerendia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE IS PROVIDED FOR THE TREATMENT OF CHRONIC KIDNEY DISEASE (CKD) ASSOCIATED WITH TYPE 2 DIABETES (T2DM). COVERAGE FOR THE TREATMENT OF HEART FAILURE WITH LEFT VENTRICULAR EJECTION FRACTION (LVEF) GREATER THAN OR EQUAL TO 40% REQUIRES A TRIAL OF AN SGLT2-INHIBITOR [E.G., JARDIANCE (EMPAGLIFLOZIN) OR FARXIGA (DAPAGLIFLOZIN)] UNLESS THE PATIENT HAS A CONTRAINDICATION OR INTOLERANCE TO AN SGLT-2 INHIBITOR.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KETOCONAZOLE

Products Affected

- Ketoconazole TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KEVZARA

Products Affected

- Kevzara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF TWO OF THE FOLLOWING: ENBREL, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM, RINVOQ, TOFACITINIB, ORENCIA. COVERAGE FOR POLYMYALGIA RHEUMATICA (PMR) REQUIRES BOTH OF THE FOLLOWING: 1) HISTORY OF TREATMENT WITH CORTICOSTEROIDS AT A DOSE OF GREATER THAN 10 MG PER DAY PREDNISONE EQUIVALENT FOR AT LEAST 8 WEEKS AND 2) INADEQUATE RESPONSE OR INTOLERANCE TO CORTICOSTEROIDS AS DEMONSTRATED BY A DISEASE FLARE DURING CORTICOSTEROID TAPER AT A DOSE OF GREATER THAN 7.5 MG PER DAY PREDNISONE EQUIVALENT. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND TRIAL OF TWO OF THE FOLLOWING: ENBREL, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM, TOFACITINIB, ORENCIA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF TWO OF THE FOLLOWING: ENBREL, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM, RINVOQ, TOFACITINIB, ORENCIA. REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KISQALI

Products Affected

- Kisqali
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION USE WITH AN AROMATASE INHIBITOR AS INITIAL ENDOCRINE-BASED THERAPY OR FULVESTRANT AS INITIAL ENDOCRINE BASED THERAPY OR FOLLOWING DISEASE PROGRESSION ON ENDOCRINE THERAPY. COVERAGE FOR THE TREATMENT OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE STAGE II AND III EARLY BREAST CANCER AT HIGH RISK OF RECURRENCE REQUIRES COMBINATION USE WITH AN AROMATASE INHIBITOR.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

KOMZIFTI

Products Affected

- Komzifti

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KORLYM

Products Affected

- Mifepristone TABS 300MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KOSELUGO

Products Affected

- Koselugo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

KRAZATI

Products Affected

- Krazati

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR THE TREATMENT OF KRAS G12C-MUTATED LOCALLY ADVANCED OR METASTIC NON-SMALL CELL LUNG CANCER REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LAZCLUZE

Products Affected

- Lazcluze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES COMBINATION USE WITH AMIVANTAMAB.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LENVIMA

Products Affected

- 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

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR RENAL CELL CARCINOMA (RCC) AS FIRST LINE THERAPY REQUIRES COMBINATION USE WITH PEMBROLIZUMAB. COVERAGE FOR RENAL CELL CARCINOMA (RCC) REQUIRES COMBINATION USE WITH EVEROLIMUS FOLLOWING ONE PRIOR ANTI-ANGIOGENIC THERAPY. COVERAGE FOR ADVANCED ENDOMETRIAL CARCINOMA (EC) REQUIRES COMBINATION USE WITH PEMBROLIZUMAB WHO HAVE DISEASE PROGRESSION FOLLOWING PRIOR SYSTEMIC THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LEUPROLIDE

Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML, 22.5MG
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LEVETIRACETAM TABLET FOR ORAL SUSPENSION

Products Affected

- Levetiracetam TB3D

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES BOTH OF THE FOLLOWING: 1) A TRIAL OF LEVETIRACETAM ORAL SOLUTION, AND 2) PATIENT IS UNABLE TO SWALLOW TABLETS OR CAPSULES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LIBERVANT

Products Affected

- Libervant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIBTAYO

Products Affected

- Libtayo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR BASAL CELL CARCINOMA (BCC) REQUIRES EITHER PRIOR TREATMENT WITH A HEDGEHOG PATHWAY INHIBITOR OR INELIGIBILITY FOR HEDGEHOG PATHWAY INHIBITOR TREATMENT.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LIDOCAINE TOPICALS

Products Affected

- Lidocaine PTCH 5%
- Lidocaine/prilocaine CREA

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 YEARS
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIFYORLI

Products Affected

- Lifyorli

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
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
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIRAGLUTIDE

Products Affected

- Liraglutide INJ 6MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	EXCLUDED IF USED FOR THE TREATMENT OF WEIGHT LOSS ONLY.
Required Medical Information	ONE OF THE FOLLOWING: A) FOR PATIENTS REQUIRING ONGOING TREATMENT FOR TYPE 2 DIABETES MELLITUS (T2DM), SUBMISSION OF MEDICAL RECORDS (E.G., CHART NOTES) CONFIRMING DIAGNOSIS OF T2DM, OR B) SUBMISSION OF MEDICAL RECORDS (E.G., CHART NOTES) CONFIRMING DIAGNOSIS OF T2DM AS EVIDENCED BY ONE OF THE FOLLOWING LABORATORY VALUES: I) A1C GREATER THAN OR EQUAL TO 6.5%, II) FASTING PLASMA GLUCOSE (FPG) GREATER THAN OR EQUAL TO 126 MG/DL, OR III) 2-HOUR PLASMA GLUCOSE (PG) GREATER THAN OR EQUAL TO 200 MG/DL DURING OGTT (ORAL GLUCOSE TOLERANCE TEST).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LIVTENCITY

Products Affected

- Livtencity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF POST-TRANSPLANT CMV INFECTION/DISEASE REQUIRES A TRIAL OF ONE OF THE FOLLOWING TREATMENTS: GANCICLOVIR, VALGANCICLOVIR, CIDOFOVIR, OR FOSCARNET.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR THE TREATMENT OF METASTATIC COLORECTAL CANCER REQUIRES COMBINATION USE WITH BEVACIZUMAB AND A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, IRINOTECAN-BASED CHEMOTHERAPY, AND AN ANTI-VEGF THERAPY. COVERAGE FOR THE TREATMENT OF RAS WILD-TYPE METATSTATIC COLORECTAL CANCER ALSO REQUIRES TRIAL OF AN ANTI-EGFR THERAPY. COVERAGE FOR THE METASTATIC GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA REQUIRES A TRIAL OF AT LEAST TWO PRIOR LINES OF CHEMOTHERAPY THAT INCLUDES FLUOROPYRIMIDINE, PLATINUM BASED, TAXANE OR IRINOTECAN-BASED CHEMOTHERAPY OR IF APPROPRIATE, AN HER2/NEU-TARGETED THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	ONE YEAR
Other Criteria	COVERAGE FOR TREATMENT OF KRAS G12C-MUTATED LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER REQUIRES A TRIAL OF AT LEAST ONE PRIOR SYSTEMIC THERAPY. COVERAGE FOR KRAS G12C-MUTATED METASTATIC COLORECTAL CANCER (mCRC) IN PATIENTS WHO HAVE RECEIVED PRIOR FLUOROPYRIMIDINE-, OXALIPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY REQUIRES COMBINATION USE WITH PANITUMUMAB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LYBALVI

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PLAN YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA IN ADULT PATIENTS REQUIRES THE TRIAL OF LURASIDONE AND PALIPERIDONE. FOR ALL OTHER INDICATIONS, COVERAGE REQUIRES THE TRIAL OF AT LEAST TWO OF THE FOLLOWING GENERIC DRUGS: ARIPIPRAZOLE, ASENAPINE, LURASIDONE, OLANZAPINE, PALIPERIDONE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LYNPARZA

Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year

Other Criteria	COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC BRCA-MUTATED ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER REQUIRES A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER REQUIRES COMBINATION USE WITH BEVACIZUMAB AND A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC BRCA-MUTATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER REQUIRES A TRIAL OF PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS gBRCAm, HER2-NEGATIVE METASTATIC BREAST CANCER REQUIRE PRIOR CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER REQUIRES PREVIOUS ENDOCRINE THERAPY OR CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS gBRCAm METASTATIC PANCREATIC ADENOCARCINOMA REQUIRES A TRIAL OF WHOSE DISEASE HAS NOT PROGRESSED ON AT LEAST 16 WEEKS OF FIRST-LINE PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE OR SOMATIC HOMOLOGUS RECOMBINATION REPAIR (HRR) GENE-MUTATED CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES A TRIAL OF ENZALUTAMIDE OR ABIRATERONE. COVERAGE FOR TREATMENT OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES COMBINATION USE WITH ABIRATERONE AND PREDNISONE OR PREDNISOLONE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

LYTGOBI

Products Affected

- Lytgobi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MARGENZA

Products Affected

- Margenza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR METASTATIC HER2-POSITIVE BREAST CANCER REQUIRES PRIOR TREATMENT WITH TWO OR MORE ANTI-HER2 REGIMENS, AT LEAST ONE OF WHICH WAS FOR METASTATIC DISEASE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MAVYRET

Products Affected

- Mavyret TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MEKINIST

Products Affected

- Mekinist TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE IS PROVIDED AS MONOTHERAPY FOR BRAF-INHIBITOR TREATEMENT-NAIVE PATIENTS WITH UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E OR V600K MUTATIONS AS DETECTED BY AN FDA APPROVED TEST. REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH BRAF V600E MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC) WITH BRAF V600E MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC SOLID TUMORS WITH BRAF V600E MUTATION WHO FAILED PRIOR TREATMENT REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR THE TREATMENT OF LOW-GRADE GLIOMA (LGG) WITH A BRAF V600E MUTATION WHO REQUIRE SYSTEMIC THERAPY AND COMBINATION USE WITH DABRAFENIB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MEKINIST LIQUID FORMULATION

Products Affected

- Mekinist SOLR

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION. COVERAGE IS PROVIDED AS MONOTHERAPY FOR BRAF-INHIBITOR TREATEMENT-NAIVE PATIENTS WITH UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E OR V600K MUTATIONS AS DETECTED BY AN FDA APPROVED TEST. REQUIRES TRIAL WITH ZELBORAF AND COTELLIC USED IN COMBINATION. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH BRAF V600E MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF LOCALLY ADVANCED OR METASTATIC ANAPLASTIC THYROID CANCER (ATC) WITH BRAF V600E MUTATION REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC SOLID TUMORS WITH BRAF V600E MUTATION WHO FAILED PRIOR TREATMENT REQUIRES COMBINATION USE WITH DABRAFENIB. COVERAGE FOR THE TREATMENT OF LOW-GRADE GLIOMA (LGG) WITH A BRAF V600E MUTATION WHO REQUIRE SYSTEMIC THERAPY AND COMBINATION USE WITH DABRAFENIB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR THE TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA REQUIRES COMBINATION USE WITH ENCORAFENIB. COVERAGE FOR THE TREATMENT OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A BRAF V600E MUTATION REQUIRES COMBINATION USE WITH ENCORAFENIB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

MEMANTINE

Products Affected

- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN 2MG/ML
- Memantine Hydrochloride TABS
- Memantine Hydrochloride Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	PRIOR AUTHORIZATION APPLIES ONLY TO PATIENTS LESS THAN 30 YEARS OF AGE.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MODEYSO

Products Affected

- Modeyso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MONJUVI

Products Affected

- Monjuvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

MOVANTIK

Products Affected

- Movantik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 1 YEAR
Other Criteria	REQUIRES A DIAGNOSIS OF OPIOID INDUCED CHRONIC CONSTIPATION IN MEMBERS WITH CHRONIC, NON-CANCER PAIN. A MEMBER MUST BE STABLE ON OPIOID THERAPY FOR A MINIMUM OF 2 WEEKS.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NARCOLEPSY AGENTS

Products Affected

- Armodafinil
- Modafinil TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NAYZILAM

Products Affected

- Nayzilam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR ADVANCED OR METASTATIC HER2-POSITIVE BREAST CANCER IN COMBINATION WITH CAPECITABINE REQURIES TREATMENT WITH TWO OR MORE PRIOR ANTI-HER2 BASED REGIMENS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NEULASTA

Products Affected

- Neulasta
- Neulasta Onpro Kit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEXAVAR

Products Affected

- Sorafenib
- Sorafenib Tosylate TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR LOCALLY RECURRENT OR METASTATIC, PROGRESSIVE, DIFFERENTIATED THYROID CARCINOMA (DTC) REQUIRES TRIAL AND FAILURE OF RADIOACTIVE IODINE TREATMENT.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NEXLETOL

Products Affected

- Nexletol

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE REQUIRES ONE OF THE FOLLOWING: 1.) DIAGNOSIS OF HYPERCHOLESTEROLEMIA, INCLUDING HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH), 2.) PATIENT HAS AN INCREASED RISK OF MAJOR ADVERSE CARDIOVASCULAR EVENTS (E.G., CARDIOVASCULAR DEATH, MYOCARDIAL INFARCTION, STROKE, OR CORONARY REVASCULARIZATION).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE TRIAL OF ONE HIGH INTENSITY STATIN, UNLESS THE PATIENT HAS EXPERIENCED INTOLERANCE TO OR HAS CONTRAINDICATIONS TO A STATIN MEDICATION. EXAMPLES OF STATIN INTOLERANCE INCLUDE SKELETAL MUSCLE RELATED SYMPTOMS OR RHABDOMYOLYSIS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NEXLIZET

Products Affected

- Nexlizet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE REQUIRES ONE OF THE FOLLOWING: 1.) DIAGNOSIS OF HYPERCHOLESTEROLEMIA, INCLUDING HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH), 2.) PATIENT HAS AN INCREASED RISK OF MAJOR ADVERSE CARDIOVASCULAR EVENTS (E.G., CARDIOVASCULAR DEATH, MYOCARDIAL INFARCTION, STROKE, OR CORONARY REVASCULARIZATION).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE TRIAL OF ONE HIGH INTENSITY STATIN, UNLESS THE PATIENT HAS EXPERIENCED INTOLERANCE TO OR HAS CONTRAINDICATIONS TO A STATIN MEDICATION. EXAMPLES OF STATIN INTOLERANCE INCLUDE SKELETAL MUSCLE RELATED SYMPTOMS OR RHABDOMYOLYSIS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR TREATMENT OF PATIENTS WITH MULTIPLE MYELOMA REQUIRES TREATMENT WITH AT LEAST ONE PRIOR THERAPY AND USE IN COMBINATION WITH LENALIDOMIDE AND DEXAMETHASONE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NINTEDANIB

Products Affected

- Nintedanib Esylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
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
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NORTHERA

Products Affected

- Droxidopa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES A TRIAL OF MIDODRINE AND FLUDROCORTISONE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	EGPA: COVERAGE REQUIRES TWO OF THE FOLLOWING CRITERIA THAT ARE TYPICAL OF EGPA: 1) HISTOPATHOLOGICAL EVIDENCE OF EOSINOPHILIC VASCULITIS, PERIVASCULAR EOSINOPHILIC INFILTRATION, OR EOSINOPHIL-RICH GRANULOMATOUS INFLAMMATION, 2) NEUROPATHY, 3) PULMONARY INFILTRATES, 4) ALLERGIC RHINITIS AND NASAL POLYPS, 5) CARDIOMYOPATHY, 6) GLOMERULONEPHRITIS, 7) ALVEOLAR HEMORRHAGE, 8) PALPABLE PURPURA, 9) ANTINEUTROPHIL CYTOPLASMIC ANTIBODY (ANCA) POSITIVITY.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR EOSINOPHILIC ASTHMA (EA) REQUIRES DIAGNOSIS OF EA WITH EOSINOPHIL COUNT OF AT LEAST 150 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR EA ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) REQUIRES A DIAGNOSIS OF EGPA. COVERAGE FOR HYPEREOSINOPHILIC SYNDROME (HES) REQUIRES DIAGNOSIS OF HES AND EOSINOPHIL COUNT OF AT LEAST 1000 CELLS PER MICROLITER AT INITIATION OF TREATMENT. COVERAGE FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). COVERAGE FOR ADD-ON MAINTENANCE TREATMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) REQUIRES A DIAGNOSIS OF UNCONTROLLED, MODERATE TO SEVERE COPD AND EITHER 1) A CURRENT EOSINOPHIL COUNT OF GREATER THAN OR EQUAL TO 150 CELLS PER MICROLITER, OR 2) AN EOSINOPHIL COUNT OF GREATER THAN OR EQUAL TO 300 CELLS PER MICROLITER WITHIN THE PAST 12 MONTHS . COVERAGE FOR COPD ALSO REQUIRES THAT THE PATIENT IS CURRENTLY RECEIVING AND WILL CONTINUE TO RECEIVE THE FOLLOWING, UNLESS CONTRAINDICATED: A LONG-ACTING BETA-2 AGONST (LABA, E.G. SALMETEROL), A LONG-ACTING MUSCARINIC ANTAGONIST (LAMA, E.G., TIOTROPIUM), AND AN INHALED CORTICOSTEROID (E.G., FLUTICASONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

NUEDEXTA

Products Affected

- Dextromethorphan Hydrobromide/quinidine Sulfate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE REQUIRES THE PRESENCE OF AN UNDERLYING NEUROLOGICAL CONDITION CAUSING SYMPTOMS OF PBA (EX. MULTIPLE SCLEROSIS, AMYOTROPHIC LATERAL SCLEROSIS, PARKINSON'S DISEASE, STROKE, TRAUMATIC BRAIN INJURY)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NUPLAZID

Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

NURTEC

Products Affected

- Nurtec

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	FOR THE ACUTE TREATMENT OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO GENERIC TRIPTANS, SUCH AS SUMATRIPTAN AND RIZATRIPTAN, UNLESS TRIPTAN THERAPY IS CONTRAINDICATED, NOT TOLERATED, OR CLINICALLY INAPPROPRIATE DUE TO OTHER CONCURRENT HEALTH CONDITIONS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OCTREOTIDE ACETATE

Products Affected

- Octreotide Acetate INJ 1000MCG/ML, 100MCG/ML, 200MCG/ML, 500MCG/ML, 50MCG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR ACROMEGALY REQUIRES TRIAL OF BROMOCRIPTINE MESYLATE AT MAXIMALLY TOLERATED DOSES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OGSIVEO

Products Affected

- Ogsiveo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJEMDA

Products Affected

- Ojemda TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJEMDA LIQUID FORMULATION

Products Affected

- Ojemda SUSR

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OJJAARA

Products Affected

- Ojjaara

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE IS PROVIDED FOR ADULT PATIENTS WITH ACUTE MYELOID LEUKEMIA WHO ACHIEVED FIRST COMPETE REMISSION (CR) OR COMPLETE REMISSION WITH INCOMPLETE BLOOD COUNT RECOVERY (CRi) FOLLOWING INTENSIVE INDUCTION CHEMOTHERAPY AND ARE NOT ABLE TO COMPLETE INTENSIVE CURATIVE THERAPY.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

OPFOLDA

Products Affected

- Opfolda

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	REQUIRES CONFIRMATION OF DIAGNOSIS BY SERUM ASSAY SHOWING A DECREASE OF ACID ALPHA-GLUCOSIDASE ACTIVITY FOLLOWED BY GENETIC TESTING SHOWING A MUTATION IN THE GAA GENE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE PRESENCE OF SYMPTOMATIC MANIFESTATIONS OF THE DISEASE INCLUDING, BUT NOT LIMITED TO: PROGRESSIVE MUSCLE WEAKNESS, RESPIRATORY FAILURE, FREQUENT UPPER AIRWAY INFECTIONS, ORTHOPNEA, SLEEP APNEA, AND/OR MORNING HEADACHES (MUST NOT BE PRESENT WITH ONLY CARDIAC HYPERTROPHY). COVERAGE REQUIRES NO IMPROVEMENT ON CURRENT ENZYME REPLACEMENT THERAPY (ERT).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OPIPZA

Products Affected

- Opipza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES PATIENT IS UNABLE TO USE ORAL TABLET OR ORAL DISINTEGRATING TABLET FORMULATIONS.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORENCIA

Products Affected

- Orencia INJ 125MG/ML, 50MG/0.4ML, 87.5MG/0.7ML
- Orencia Clickject

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH OTHER IMMUNOSUPPRESSIVES (E.G., JAK INHIBITORS, BIOLOGIC DMARDS)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING ABATACEPT IN COMBINATION WITH OTHER IMMUNOSUPPRESSIVES (E.G., JAK INHIBITORS, BIOLOGIC DMARDS).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORENITRAM

Products Affected

- Orenitram

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE IS PROVIDED FOR THE DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION. REQUIRES TRIAL AND FAILURE OR CONTRAINDICATION TO SILDENAFIL.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORFADIN

Products Affected

- Nitisinone

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE REQUIRES THE TRIAL OF OR INTOLERANCE TO FIRMAGON. FOR MA-PD PLANS, THE TRIAL OF FIRMAGON MAY BE PART B BEFORE PART D STEP THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ORSERDU

Products Affected

- Orserdu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ER-POSITIVE, HER2-NEGATIVE, ESR1-MUTATED ADVANCED OR METASTATIC BREAST CANCER WITH DISEASE PROGRESSION REQUIRES PRIOR TREATMENT WITH AT LEAST ONE LINE OF ENDOCRINE THERAPY
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

OTEZLA

Products Affected

- Otezla
- Otezla Xr
- Otezla/otezla Xr 28 Day Treatment Initiation Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF PLAQUE PSORIASIS. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PADCEV

Products Affected

- Padcev

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR LOCALLY ADVANCED OR METASTATIC UROTHELIAL CANCER REQUIRES PRIOR TREATMENT WITH A PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH-LIGAND 1 (PD-L1) INHIBITOR AND PLATINUUM-CONTAINING CHEMOTHERAPY OR ARE INELIGIBLE FOR CISPLATING-CONTAINING CHEMOTHERAPY AND HAVE PREVIOUSLY RECEIVED ONE OR MORE PRIOR LINES OF THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PANRETIN

Products Affected

- Panretin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PHENOBARBITAL

Products Affected

- Phenobarbital ELIX 20MG/5ML
- Phenobarbital TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PIQRAY

Products Affected

- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR TREATMENT OF ADULTS WITH HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, PIK3CA-MUTATED, ADVANCED OR METASTATIC BREAST CANCER REQUIRES PROGRESSION ON OR AFTER AN ENDOCRINE-BASED REGIMEN AND COMBINATION THERAPY WITH FULVESTRANT.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

POLIVY

Products Affected

- Polivy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR RELAPSED OR REFRACTORY DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), NOT OTHERWISE SPECIFIED (NOS) REQUIRES TRIAL OF AT LEAST TWO PRIOR THERAPIES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

POMALYST

Products Affected

- Pomalidomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR MULTIPLE MYELOMA REQUIRES 1) AT LEAST TWO PRIOR THERAPIES, INCLUDING LENALIDOMIDE AND A PROTEASOME INHIBITOR, IN PATIENTS WHO HAVE DEMONSTRATED DISEASE PROGRESSION ON OR WITHIN 60 DAYS OF COMPLETION OF THE LAST THERAPY, AND 2)COMBINATION USE WITH DEXAMETHASONE. COVERAGE FOR AIDS-RELATED KAPOSI SARCOMA (KS) REQUIRES TRIAL AND FAILURE OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

POSACONAZOLE DR

Products Affected

- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 MONTHS
Other Criteria	COVERAGE FOR PROPHYLAXIS OF INVASIVE FUNGAL INFECTIONS (IFI): USED AS PROPHYLAXIS OF INVASIVE FUNGAL INFECTIONS CAUSED BY ASPERGILLUS OR CANDIDA FOR ONE OF THE FOLLOWING CONDITIONS: 1) PATIENT IS AT HIGH RISK OF INFECTIONS DUE TO SEVERE IMMUNOSUPPRESSION FROM HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) WITH GRAFT-VERSUS-HOST DISEASE (GVHD) OR HEMATOLOGIC MALIGNANCIES WITH PROLONGED NEUTROPENIA FROM CHEMOTHERAPY [E.G., ACUTE MYELOID LEUKEMIA (AML), MYELODYSPLASTIC SYNDROME (MDS)], OR 2) PATIENT HAS A PRIOR FUNGAL INFECTION REQUIRING SECONDARY PROPHYLAXIS. COVERAGE FOR PROPHYLAXIS ALSO REQUIRES TRIAL WITH TWO OF THE FOLLOWING: FLUCONAZOLE, ITRACONAZOLE OR VORICONAZOLE. COVERAGE FOR TREATMENT OF IFI: USED AS TREATMENT OF INVASIVE FUNGAL INFECTIONS CAUSED BY ASPERGILLUS AND CANDIDA. COVERAGE FOR TREATMENT ALSO REQUIRES TRIAL WITH TWO OF THE FOLLOWING: FLUCONAZOLE, ITRACONAZOLE OR VORICONAZOLE.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A

Required Medical Information	ASCVD (INIT): CONFIRMATION THAT PT IS AT INCREASED RISK FOR ONE OF THE FOLLOWING CV EVENTS: CV DEATH, MI, STROKE, OR UNSTABLE ANGINA REQUIRING HOSPITALIZATION. PRIMARY HLD (INIT): DIAGNOSIS OF PRIMARY HYPERLIPIDEMIA (HLD). HeFH (INIT): HeFH AS CONF BY ONE OF THE FOLLOWING: (1) BOTH OF THE FOLLOWING: A) UNTREATED/PRE-TREATMENT LDL GREATER THAN 190 MG/DL REQUIRED FOR ADULTS ONLY, AND B) ONE OF THE FOLLOWING: 1) FAMILY HX OF TENDINOUS XANTHOMA(S) IN 1ST/2ND DEG RELATIVES AND/OR ARCUS CORNEALIS IN 1ST DEG RELATIVE, 2) HX OF MI IN 1ST DEG RELATIVE UNDER 60 YRS/1ST DEG RELATIVE WITH KNOWN PREMATURE CORONARY AND VASCULAR DISEASE (UNDER 55 YRS IN MEN, UNDER 60 YRS IN WOMEN), 3) FAMILY HX OF MI IN 2ND DEG RELATIVE LESS THAN 50 YRS OF AGE, 4) FAMILY HX OF LDL-C GREATER THAN 290 MG/DL IN 1ST/2ND DEG RELATIVE, 5) FAMILY HX OF FH IN 1ST/2ND DEG RELATIVE, OR (2) UNTREATED/PRE-TREATMENT LDL-C GREATER THAN 190 MG/DL REQUIRED FOR ADULTS ONLY AND ONE OF THE FOLLOWING: PRESENCE OF TENDINOUS XANTHOMA IN PT, ARCUS CORNEALIS BEFORE AGE 45, OR FUNCTIONAL MUTATION IN THE LDL RECEPTOR, APOB, OR PCSK9 GENE. ASCVD/PRIMARY HLD/HeFH (INIT), ONE OF THE FOLLOWING: LDL VALUES WHILE ON A HIGH INTENSITY STATIN (ATORVASTATIN 40-80MG OR ROSUVASTATIN 20-40MG) W/IN THE LAST 120 DAYS: (1) LDL OVER/EQUAL TO 55 MG/DL W/ASCVD, OR (2) LDL OVER 70 MG/DL W/O ASCVD. ONE OF THE FOLLOWING: (1) PT HAS BEEN RECEIVING AT LEAST 12 WKS OF HIGH INTENSITY STATIN AND WILL CONTINUE TO RECEIVE A STATIN AT MAX TOLERATED DOSE, (2) PT IS UNABLE TO TOLERATE STATIN (E.G., MYALGIA, MYOSITIS, RHABDOMYOLYSIS) AND HAS TRIED ATORVASTATIN AND ROSUVASTATIN. HoFH (INIT): DX OF HOFH AS CONF BY ONE OF THE FOLLOWING: (1) GEN CONF OF 2 MUTATIONS IN LDL RECEPTOR, APOB, PCSK9, LDLRAP1 OR ARH, OR (2) EITHER UNTREATED LDL OVER 500 OR TREATED LDL OVER 300, AND EITHER XANTHOMA BEFORE 10 YO OR EVIDENCE OF HEFH IN BOTH PARENTS. PT IS RECEIVING OTHER LIPID-LOWERING TX.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 YEARS

Other Criteria	HeFH/ASCVD/PRIMARY HLD (REAUTH): PT CONTINUES TO RECEIVE STATIN AT MAX TOLERATED DOSE (UNLESS PT HAS DOCUMENTED INABILITY TO TAKE STATINS OR CANNOT TOLERATE STATINS). PT HAS EXPERIENCED LDL REDUCTION WHILE ON PRALUENT TX. HoFH (REAUTH): PT CONTINUES TO RECEIVE OTHER LIPID-LOWERING TX (EG STATIN, EZETIMIBE). PT HAS EXPERIENCED LDL REDUCTION WHILE ON PRALUENT TX.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PREVYMIS

Products Affected

- Prevymis PACK
- Prevymis TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR CYTOMEGALOVIRUS (CMV) PROPHYLAXIS, IN CMV-SEROPOSITIVE RECIPIENT [R+] OF AN ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT), OR, IN KIDNEY TRANSPLANT RECIPIENTS AT HIGH RISK [DONOR IS CMV SEROPOSITIVE/RECIPIENT IS CMV SERONEGATIVE: D+/R-]
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PROLIA

Products Affected

- Jubbonti
- Stoboclo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	COVERAGE IS NOT PROVIDED FOR HYPOCALCEMIA.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 YEARS
Other Criteria	JUBBONTI AND STOBOCLO ARE SUBJECT TO PART B VERSUS PART D REVIEW. COVERAGE REQUIRES TRIAL OF AN ORAL BISPHOSPHONATE OR, IF INTOLERANT, AN INTRAVENOUS BISPHOSPHONATE. COVERAGE IS ALSO PROVIDED IF THE PATIENT IS UNABLE TO BE TREATED WITH BOTH ORAL AND INTRAVENOUS BISPHOSPHONATES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PROMACTA

Products Affected

- Eltrombopag Olamine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE FOR A DIAGNOSIS OF PERSISTANT OR CHRONIC IMMUNE THROMBOCYTOPENIA (ITP) REQUIRES BASELINE PLATELET COUNT OF LESS THAN 30,000 MCL. COVERAGE FOR A DIAGNOSIS OF THROMBOCYTOPENIA WITH CHRONIC HEPATITIS C REQUIRES BASELINE PLATELET COUNT LESS THAN 75,000 MCL. COVERAGE FOR A DIAGNOSIS OF SEVERE APLASTIC ANEMIA REQUIRES BASELINE PLATELET COUNT OF LESS THAN 30,000 MCL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR ITP REQUIRES TRIAL OF CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS

Products Affected

- Alyq
- Ambrisentan
- Bosentan TABS
- Sildenafil Citrate TABS 20MG
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR ADULT PATIENTS WITH ADVANCED GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES PRIOR THERAPY WITH 3 OR MORE KINASE INHIBITORS, INCLUDING IMATINIB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

QUININE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

QULIPTA

Products Affected

- Qulipta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RALDESY

Products Affected

- Raldesy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLET FORMULATION.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE IS PROVIDED FOR ADULT PATIENTS WITH LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A REARRANGED DURING TRANSFECTION (RET) GENE FUSION, AS DETECTED BY AN FDA-APPROVED TEST. COVERAGE IS PROVIDED FOR ADULT AND PEDIATRIC PATIENTS 2 YEARS OF AGE AND OLDER WITH ADVANCED OR METASTATIC MEDULLARY THYROID CANCER (MTC) WITH A RET MUTATION AS DETECTED BY AN FDA-APPROVED TEST, WHO REQUIRE SYSTEMIC THERAPY. COVERAGE FOR ADULT AND PEDIATRIC PATIENTS 2 YEARS OF AGE AND OLDER WITH ADVANCED OR METASTATIC THYROID CANCER WITH A RET-GENE FUSION AS DETECTED BY AN FDA-APPROVED TEST REQUIRES TRIAL AND FAILURE WITH RADIOACTIVE IODINE (IF RADIOACTIVE IODINE IS APPROPRIATE). COVERAGE FOR ADULT AND PEDIATRIC PATIENTS 2 YEARS OF AGE AND OLDER WITH LOCALLY ADVANCED OR METASTATIC SOLID TUMORS WITH A RET-GENE FUSION IS PROVIDED FOR THOSE PATIENTS WHO HAVE PROGRESSED ON OR FOLLOWING PRIOR SYSTEMIC TREATMENT.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REVCOVI

Products Affected

- Revcovi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVLIMID

Products Affected

- Lenalidomide

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR MULTIPLE MYELOMA REQUIRES COMBINATION USE WITH DEXAMETHASONE. COVERAGE FOR MANTLE CELL LYMPHOMA REQUIRES DISEASE RELAPSE OR PROGRESSION AFTER TWO PRIOR THERAPIES, ONE OF WHICH INCLUDES BORTEZOMIB. COVERAGE FOR PREVIOUS TREATED FOLLICULAR LYMPHOMA OR PREVIOUSLY TREATED MARGINAL ZONE LYMPHOMA REQUIRES COMBINATION USE WITH A RITUXIMAB PRODUCT.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REVUFORJ

Products Affected

- Revuforj

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

REZDIFFRA

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE REQUIRES A DIAGNOSIS OF NONCIRRHOTIC NONALCOHOLIC STEATOHEPATITIS (NASH) OR METABOLIC DYSFUNCTION-ASSOCIATED STEATOHEPATITIS (MASH) AND THE PRESENCE OF ADVANCED LIVER FIBROSIS (STAGE F2 TO F3) VERIFIED BY FIBROSCAN OR OTHER IMAGING-BASED NON-INVASIVE LIVER DISEASE ASSESSMENT.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR.
Other Criteria	COVERAGE FOR A DIAGNOSIS OF NASH OR MASH REQUIRES A TRIAL OF SEMAGLUTIDE. RENEWAL REQUIRES THAT THE PATIENT HAS NOT PROGRESSED TO CIRRHOSIS AND ONE OF THE FOLLOWING: 1. NASH/ MASH RESOLUTION AND NO WORSENING OF FIBROSIS, 2. IMPROVEMENT IN FIBROSIS BY GREATER THAN OR EQUAL TO 1 STAGE WITH NO WORSENING OF NASH/ MASH OR THAT THE MEDICATION IS PROVIDING CLINICAL BENEFIT, OR 3. IMPROVEMENT OR STABILIZATION OF NASH/ MASH DEMONSTRATED BY IMAGING OR BLOOD BASED NON-INVASIVE LIVER DISEASE ASSESSMENT.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

REZLIDHIA

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE) OR WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC. COVERAGE FOR NONRADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (AXSPA) REQUIRES A DIAGNOSIS OF NON-RADIOGRAPHIC AXSPA AND OBJECTIVE SIGNS OF INFLAMMATION. COVERAGE FOR NON-RADIOGRAPHIC AXSPA ALSO REQUIRES THE TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD. COVERAGE FOR RA, PSA, UC, AS, CD, AND AXSPA ALSO REQUIRES AN INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF INHIBITORS (E.G., ENBREL, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM) OR DOCUMENTATION DEMONSTRATING THAT A TRIAL MAY BE INAPPROPRIATE. COVERAGE FOR ATOPIC DERMATITIS (AD) REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE ATOPIC DERMATITIS AND A TRIAL AND TREATMENT FAILURE OF ONE OF THE FOLLOWING: HIGH POTENCY TOPICAL CORTICOSTEROID, TACROLIMUS, PIMECROLIMUS, CYCLOSPORINE, AZATHIOPRINE OR MYCOPHENOLATE MOFETIL. COVERAGE FOR GIANT CELL ARTERITIS (GCA) REQUIRES A DIAGNOSIS OF GCA. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING UPADACITINIB IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RINVOQ LIQUID FORMULATION

Products Affected

- Rinvoq Lq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE) OR WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING UPADACITINIB IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ROMVIMZA

Products Affected

- Romvimza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE IS PROVIDED FOR THE MAINTENANCE TREATMENT OF ADULT PATIENTS WITH A DELETERIOUS BRCA MUTATION-ASSOCIATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER WHO ARE IN COMPLETE OR PARTIAL RESPONSE TO PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR PATIENTS WITH A DELETERIOUS BRCA MUTATION-ASSOCIATED METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (MCRPC) REQUIRES PREVIOUS THERAPY WITH ANDROGEN RECEPTOR-DIRECTED THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RYBREVANT

Products Affected

- Rybrevant

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 20 INSERTION MUTATIONS REQUIRES DISEASE PROGRESSION ON OR AFTER PLATINUM-BASED CHEMOTHERAPY. COVERAGE FOR TREATMENT OF ADULT PATIENTS WITH LOCALLY ADVANCED OR METASTATIC NSCLC WITH EGFR EXON 19 DELETIONS OR EXON 21 L858R SUBSTITUTION MUTATIONS WHOSE DISEASE HAS PROGRESSED ON OR AFTER TREATMENT WITH AN EGFR TYROSINE KINASE INHIBITOR REQUIRES COMBINATION USE WITH CARBOPLATIN AND PEMETREXED.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) THAT IS FLT3 MUTATION-POSITIVE REQUIRES COMBINATION THERAPY WITH STANDARD CYTARABINE AND DAUNORUBICIN INDUCTION AND CYTARABINE CONSOLIDATION.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

RYLAZE

Products Affected

- Rylaze

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SAPROPTERIN HYDROCHLORIDE

Products Affected

- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	INITIAL - 2 MONTHS AUTH WILL BE EXTENDED FOR 1 YEAR IF DOCUMENTED RESPONSE AFTER INITIAL THERAPY
Other Criteria	RENEWAL CRITERIA: PATIENT MUST SHOW IMPROVEMENT AFTER INITIAL THERAPY OF 2 MONTHS.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SARCLISA

Products Affected

- Sarclisa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR MULTIPLE MYELOMA REQUIRES TREATMENT WITH AT LEAST 2 PRIOR THERAPIES, INCLUDING LENALIDOMIDE AND A PROTEASOME INHIBITOR. COVERAGE FOR RELAPSED OR REFRACTORY MULTIPLE MYELOMA REQUIRES TREATMENT WITH 1 TO 3 PRIOR LINES OF THERAPY. COVERAGE FOR ADULT PATIENTS WITH NEWLY DIAGNOSED MULTIPLE MYELOMA WHO ARE NOT ELIGIBLE FOR AUTOLOGOUS STEM CELL TRANSPLANT (ASCT) REQUIRES COMBINATION USE WITH BORTEZOMIB, LENALIDOMIDE AND DEXAMETHASONE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SCEMBLIX

Products Affected

- Scemblix

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SECUADO

Products Affected

- Secuado

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	LIFETIME
Other Criteria	COVERAGE FOR THE TREATMENT OF SCHIZOPHRENIA REQUIRES A TRIAL OF ASENAPINE TABLET (SUBLINGUAL), OR PATIENT HAS A DOCUMENTED DIFFICULTY WITH THE USE OF ORAL OR ORALLY DISINTEGRATING TABLET (ODT) FORMULATIONS
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES BEDAQUILINE BE USED AS PART OF A COMBINATION REGIMEN.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SKYRIZI

Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML, 55MG/0.37ML, 600MG/10ML
- Skyrizi Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSORIATIC ARTHRITIS. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF CHRONIC MODERATE TO SEVERE PLAQUE PSORIASIS. COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD. COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOMATULINE DEPOT

Products Affected

- Lanreotide Acetate
- Somatuline Depot

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SPRITAM

Products Affected

- Spritam

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SPRYCEL

Products Affected

- Dasatinib

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR CHRONIC MYELOGENOUS LEUKEMIA (CML) REQUIRES TRIAL OF IMATINIB. COVERAGE FOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) REQUIRES ONE OF THE FOLLOWING: 1) SPRYCEL TO BE USED IN COMBINATION WITH CHEMOTHERAPY IN NEWLY DIAGNOSED ALL OR 2) RESISTANCE OR INTOLERANCE TO PRIOR THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

STELARA

Products Affected

- Stelara
- Ustekinumab
- Wezlana INJ 45MG/0.5ML, 90MG/ML
- Yesintek INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR PLAQUE PSORIASIS REQUIRES A DIAGNOSIS OF MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS. COVERAGE FOR CROHN'S DISEASE (CD) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CD. COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR COLORECTAL CANCER (CRC) REQUIRES PREVIOUS TREATMENT WITH FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED CHEMOTHERAPY, AN ANTI-VEGF THERAPY, AND, IF RAS WILD-TYPE, AN ANTI-EGFR THERAPY. COVERAGE FOR GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES PREVIOUS TREATMENT WITH IMATINIB MESYLATE AND SUNITINIB MALATE. COVERAGE FOR HEPATOCELLULAR CARCINOMA (HCC) REQUIRES PREVIOUS TREATMENT WITH SORAFENIB.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SUBVENITE ORAL SUSPENSION

Products Affected

- Subvenite SUSP

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW TABLETS, CHEWABLE TABLETS OR ORALLY DISINTEGRATING TABLETS.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

SUNOSI

Products Affected

- Sunosi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES A TRIAL OF ARMODAFINIL
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SUTENT

Products Affected

- Sunitinib Malate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR GASTROINTESTINAL STROMAL TUMOR (GIST) REQUIRES DISEASE PROGRESSION ON OR INTOLERANCE TO IMATINIB MESYLATE
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

SYMPAZAN

Products Affected

- Clobazam SUSP 2.5MG/ML
- Clobazam TABS
- Sympazan

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TABLOID

Products Affected

- Tabloid

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist or hematologist.
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAFINLAR

Products Affected

- Tafinlar CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF SOLID TUMORS REQUIRES DISEASE PROGRESSION FOLLOWING PRIOR TREATMENT. COVERAGE FOR THE FOLLOWING REQUIRES TAFINLAR TO BE USED IN COMBINATION WITH TRAMETINIB: 1) TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600K MUTATION, 2) ADJUVANT TREATMENT OF MELANOMA WITH LYMPH NODE INVOLVEMENT FOLLOWING COMPLETE RESECTION, 3) TREATMENT OF NON-SMALL CELL LUNG CANCER (NSCLC), 4) TREATMENT OF ANAPLASTIC THYROID CANCER (ATC), 5) TREATMENT OF SOLID TUMORS, 6) LOW GRADE GLIOMA (LGG).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAFINLAR LIQUID FORMULATION

Products Affected

- Tafinlar TBSO

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION REQUIRES A TRIAL OF VEMURAFENIB (ZELBORAF) AND COBIMETINIB (COTELLIC) USED IN COMBINATION. COVERAGE FOR TREATMENT OF SOLID TUMORS REQUIRES DISEASE PROGRESSION FOLLOWING PRIOR TREATMENT. COVERAGE FOR THE FOLLOWING REQUIRES TAFINLAR TO BE USED IN COMBINATION WITH TRAMETINIB: 1) TREATMENT OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600K MUTATION, 2) ADJUVANT TREATMENT OF MELANOMA WITH LYMPH NODE INVOLVEMENT FOLLOWING COMPLETE RESECTION, 3) TREATMENT OF NON-SMALL CELL LUNG CANCER (NSCLC), 4) TREATMENT OF ANAPLASTIC THYROID CANCER (ATC), 5) TREATMENT OF SOLID TUMORS, 6) LOW GRADE GLIOMA (LGG). COVERAGE FOR ALL CONDITIONS REQUIRES THAT THE PATIENT IS UNABLE TO SWALLOW CAPSULE FORMULATION.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETION- OR EXON 21 L858R MUTATION-POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES TAGRISSO TO BE USED 1) AS ADJUVANT THERAPY AFTER TUMOR RESECTION, 2) AS FIRST-LINE TREATMENT IN METASTATIC DISEASE, OR 3) AS FIRST-LINE TREATMENT IN LOCALLY ADVANCED OR METASTATIC DISEASE IN COMBINATION WITH PEMETREXED AND PLANTIUM-BASED CHEMOTHERAPY. COVERAGE FOR EGFR T790M MUTATION-POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES DISEASE PROGRESSION ON OR AFTER EGFR TYROSINE KINASE INHIBITOR (TKI) THERAPY. COVERAGE IS ALSO PROVIDED FOR TREATMENT OF ADULT PATIENTS WITH LOCALLY ADVANCED, UNRESECTABLE (STAGE III) NSCLC WITH EGFR EXON 19 DELETIONS OR EXON 21 L8F8R MUTATIONS WHOSE DISEASE HAS NOT PROGRESSED DURING OR FOLLOWING CONCURRENT OR SEQUENTIAL PLATINUM-BASED CHEMORADIATION THERAPY.

Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (mCRPC) REQUIRES TALZENNA TO BE USED IN COMBINATION WITH ENZALUTAMIDE
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TARCEVA

Products Affected

- Erlotinib Hydrochloride TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR NON-SMALL CELL LUNG CANCER (NSCLC) REQUIRES CONCURRENT TREATMENT WITH FIRST-LINE, MAINTENANCE, OR SECOND OR GREATER LINE TREATMENT AFTER PROGRESSION FOLLOWING AT LEAST ONE PRIOR CHEMOTHERAPY REGIMEN. COVERAGE FOR PANCREATIC CANCER REQUIRES THAT ERLOTINIB IS USED IN COMBINATION WITH GEMCITABINE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TARGRETIN

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a dermatologist or oncologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR BEXAROTENE CAPSULE FOR CUTANEOUS T-CELL LYMPHOMA REQUIRES THAT THIS CONDITION IS REFRACTORY TO AT LEAST ONE PRIOR SYSTEMIC THERAPY. COVERAGE FOR BEXAROTENE GEL FOR CUTANEOUS T-CELL LYMPHOMA REQUIRES THAT THIS CONDITION IS REFRACTORY TO, PERSISTENT AFTER, OR INTOLERANT OF OTHER THERAPIES.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TASIGNA

Products Affected

- Nilotinib Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR ADULT PATIENTS WITH CHRONIC PHASE (CP) CML NOT NEWLY DIAGNOSED AND ACCELERATED PHASE (AP) PH+ CML REQUIRES A TRIAL OF PRIOR THERAPY THAT INCLUDED IMATINIB. COVERAGE FOR PEDIATRIC PATIENTS WITH PH+ CML-CP AND CML-AP REQUIRES A TRIAL OF A TYROSINE-KINASE INHIBITOR (TKI) THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TAVNEOS

Products Affected

- Tavneos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAZAROTENE

Products Affected

- Tazarotene CREA 0.1%
- Tazarotene GEL 0.05%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR EZH2 MUTATION-POSITIVE FOLLICULAR LYMPHOMA REQUIRES PRIOR TREATMENT WITH AT LEAST TWO SYSTEMIC THERAPIES
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TECFIDERA

Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack CDPK 0

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TESTOSTERONE

Products Affected

- Testosterone Pump GEL 12.5MG/ACT, 20.25MG/ACT

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	COVERAGE WILL NOT BE PROVIDED IN THE FOLLOWING SITUATIONS, 1) HEPATIC FUNCTION IMPAIRMENT 2) ACTIVELY SUICIDAL OR WHO HAVE UNTREATED OR INADEQUATELY TREATED DEPRESSION, 3) TAKING MONOAMINE OXIDASE INHIBITORS OR RESERPINE.
Required Medical Information	DOCUMENTATION OF THE CYP2D6 GENOTYPE OF THE PATIENT WILL BE REQUIRED FOR DOSES ABOVE 50MG PER DAY.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

THALOMID

Products Affected

- Thalomid CAPS 100MG, 50MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR MULTIPLE MYELOMA (MM) REQUIRES THALOMID TO BE USED IN COMBINATION WITH DEXAMETHASONE. COVERAGE FOR ACUTE TREATMENT OF ERYTHEMA NODOSUM LEPROSUM (ENL) WITH PRESENCE OF MODERATE TO SEVERE NEURITIS REQUIRES THALOMID TO BE PART OF A COMBINATION THERAPY.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR CHOLANGIOCARCINOMA REQUIRES PREVIOUS TREATMENT
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TIVDAK

Products Affected

- Tivdak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR RECURRENT OR METASTATIC CERVICAL CANCER REQUIRES DISEASE PROGRESSION ON OR AFTER CHEMOTHERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOCILIZUMAB

Products Affected

- Avtozma INJ 162MG/0.9ML
- Tyenne INJ 162MG/0.9ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF TWO OF THE FOLLOWING: ENBREL, ADALIMUMAB-AATY or ADALIMUMAB-ADBM, RINVOQ, TOFACITINIB, ORENCIA. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND TRIAL OF TWO OF THE FOLLOWING: ENBREL, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM, TOFACITINIB, ORENCIA. COVERAGE FOR SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA) REQUIRES A DIAGNOSIS OF ACTIVE SJIA AND A TRIAL OF ONE OF THE FOLLOWING DRUGS: A NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN), A SYSTEMIC GLUCOCORTICOID (E.G., PREDNISONE), OR METHOTREXATE (RHEUMATREX/TREXALL). COVERAGE FOR GIANT CELL ARTERITIS (GCA) REQUIRES A DIAGNOSIS OF GCA. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TOPICAL TRETINOIN

Products Affected

- Tretinoin CREA
- Tretinoin GEL 0.01%, 0.025%

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRIENTINE

Products Affected

- Trientine Hydrochloride CAPS 250MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR WILSON'S DISEASE WHO ARE INTOLERANT TO PENCILLAMINE.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TRODELVY

Products Affected

- Trodelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR UNRESECTABLE LOCALLY ADVANCED OR METASTATIC TRIPLE-NEGATIVE BREAST CANCER (MTNBC) REQUIRES PRIOR USE OF TWO OR MORE SYSTEMIC THERAPIES, WITH AT LEAST ONE OF THEM FOR METASTATIC DISEASE. COVERAGE FOR UNRESECTABLE LOCALLY ADVANCED OR METASTATIC HORMONE RECEPTOR POSITIVE (HR+), HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 NEGATIVE (HER2-) (IHC 0, IHC 1+ OR IHC 2+/ISH-) BREAST CANCER REQUIRES PRIOR USE OF ENDOCRINE-BASED THERAPY AND AT LEAST TWO ADDITIONAL SYSTEMIC THERAPIES IN THE METASTATIC SETTING. COVERAGE FOR FIRST LINE TREATMENT OF UNRESECTABLE LOCALLY ADVANCED OR MTNBC WHOSE TUMORS EXPRESS PD-L1 (CPS GREATER THAN OR EQUAL TO 10) REQUIRES COMBINATION USE WITH PEMBROLIZUMAB OR PEMBROLIZUMAB AND BERAHYALURONIDASE ALFA-PMPH.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TRUQAP

Products Affected

- Truqap

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, LOCALLY ADVANCED OR METASTATIC BREAST CANCER WITH ONE OR MORE PIK3CA/AKT1/PTEN-ALTERACTIONS REQUIRES PROGRESSION ON AT LEAST ONE ENDOCRINE BASED REGIMEN OR RECURRENCE ON OR WITHIN 12 MONTHS OF COMPLETING ADJUVANT THERAPY AND COMBINATION USE WITH FULVESTRANT. COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH METASTATIC ANDROGEN PATHWAY MODULATION-NAIVE OR SENSITIVE (MAPMN/S) PROSTATE CANCER THAT IS PTEN-DEFICIENT REQUIRES COMBINATION USE WITH ABIRATERONE AND PREDNISONE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR ADVANCED UNRESCETABLE OR METASTATIC HER2-POSITIVE BREAST CANCER REQUIRES A TRIAL OF ONE OR MORE PRIOR ANTI-HER2-BASED REGIMENS AND COMBINATION THERAPY WITH TRASTUZUMAB AND CAPECITABINE. COVERAGE FOR RAS WILD-TYPE HER2-POSITIVE UNRESECTABLE OR METASTATIC COLORECTAL CANCER REQUIRES A TRIAL OF FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED CHEMOTHERAPY AND COMBINATION THERAPY WITH TRASTUZUMAB
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TURALIO

Products Affected

- Turalio CAPS 125MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

TYKERB

Products Affected

- Lapatinib Ditosylate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR ADVANCED OR METASTATIC BREAST CANCER WHOSE TUMORS OVEREXPRESS HER2 RECEPTOR REQUIRES A TRIAL OF PRIOR THERAPY INCLUDING AN ARTHRACYCLINE, A TAXANE, AND TRASTUZUMAB AND COMBINATION USE WITH CAPECITABINE. COVERAGE FOR HORMONE RECEPTOR-POSITIVE METASTATIC BREAST CANCER THAT OVEREXPRESS HER2 RECEPTORS AND COMBINATION USE WITH LETROZOLE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	REQUIRES DOCUMENTATION OF BONE MINERAL DENSITY THAT IS 2.5 STANDARD DEVIATIONS OR MORE BELOW THE MEAN (T-SCORE AT OR BELOW -2.5).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 Years
Other Criteria	COVERAGE REQUIRES TRIAL OF BOTH 1) JUBBONTI OR STOBOCLO AND 2) EITHER AN ORAL BISPHOSPHONATE OR, IF INTOLERANT, AN INTRAVENOUS BISPHOSPHONATE. COVERAGE IS ALSO PROVIDED IF THE PATIENT IS UNABLE TO BE TREATED WITH ALL OF THE FOLLOWING: JUBBONTI OR STOBOCLO, AN ORAL BISPHOSPHONATE, AND AN INTRAVENOUS BISPHOSPHONATE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

UBRELVY

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	FOR THE ACUTE TREATMENT OF MIGRAINE HEADACHES, COVERAGE REQUIRES TRIAL OF AT LEAST TWO GENERIC TRIPTANS, SUCH AS SUMATRIPTAN AND RIZATRIPTAN, UNLESS TRIPTAN THERAPY IS CONTRAINDICATED, NOT TOLERATED, OR CLINICALLY INAPPROPRIATE DUE TO OTHER CONCURRENT HEALTH CONDITIONS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR TOPICAL TREATMENT OF STAGE 1A AND 1B MYCOSIS FUNGOIDES-TYPE CUTANEOUS T-CELL LYMPHOMA REQUIRES PRIOR SKIN-DIRECTED THERAPY.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VALTOCO

Products Affected

- Valtoco 10 Mg Dose
- Valtoco 15 Mg Dose
- Valtoco 20 Mg Dose
- Valtoco 5 Mg Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VANFLYTA

Products Affected

- Vanflyta

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) THAT IS FLT3 INTERNAL TANDEM DUPLICATION (ITD) POSITIVE REQUIRES USE IN COMBINATION WITH STANDARD CYTARABINE AND ANTHRACYCLINE INDUCTION AND CYTARABINE CONSOLIDATION.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR NEWLY DIAGNOSED ACUTE MYELOID LEUKEMIA (AML) IN ADULTS 75 YEARS OR OLDER OR WHO HAVE COMORBITITIES THAT PRECLUDE USE OF INTENSIVE INDUCTION CHEMOTHERAPY REQUIRES COMBINATION USE WITH AZACITIDINE, DECITABINE, OR LOW-DOSE CYTARABINE.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VEOZAH

Products Affected

- Veozah

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR MODERATE-TO-SEVERE VASOMOTOR SYMPTOMS (VMS) DUE TO MENOPAUSE REQUIRES A TRIAL, FAILURE, CONTRAINDICATION OR INTOLERANCE TO ONE PREFERRED OR GENERIC MEDICATION FOR THE TREATMENT OF VMS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VEPPANU

Products Affected

- Veppanu

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PLAN YEAR
Other Criteria	COVERAGE FOR ESTROGEN RECEPTOR (ER)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, ESTROGEN RECEPTOR-1 (ESR1)-MUTATED ADVANCED OR METASTATIC BREAST CANCER REQUIRES DISEASE PROGRESSION FOLLOWING AT LEAST ONE LINE OF ENDOCRINE THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VERQUVO

Products Affected

- Verquvo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE REQUIRES A DIAGNOSIS OF CHRONIC HEART FAILURE NEW YORK HEART ASSOCIATION (NYHA) CLASS II-IV AND LEFT VENTRICULAR EJECTION FRACTION (LVEF) OF LESS THAN 45%. COVERAGE ALSO REQUIRES ONE OF THE FOLLOWING: 1. PREVIOUS HOSPITALIZATION FOR HEART FAILURE WITHIN PRIOR 6 MONTHS OR 2. OUTPATIENT INTRAVENOUS (IV) DIURETIC TREATMENT FOR HEART FAILURE WITHIN PRIOR 3 MONTHS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	MUST BE TAKEN IN COMBINATION WITH AT LEAST TWO OF THE FOLLOWING UNLESS CONTRAINDICATED OR NOT TOLERATED: 1. METOPROLOL SUCCINATE, CARVEDILOL, OR BISOPROLOL 2. AN ACE-INHIBITOR (ACE, SUCH AS LISINOPRIL), ANGIOTENSIN RECEPTOR BLOCKER (ARB, SUCH AS LOSARTAN), OR ANGIOTENSIN RECEPTOR-NEPRILYSIN INHIBITOR (ARNI, SUCH AS SACUBITRIL/VALSARTAN) 3. A SODIUM GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR APPROVED FOR HEART FAILURE 4. A MINERALOCORTICOID RECEPTOR ANTAGONIST
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR THE ADJUVANT TREATMENT OF ADULT PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2)-NEGATIVE, NODE POSITIVE, EARLY BREAST CANCER AT HIGH RISK OF RECUURENCE REQUIRES COMBINATION USE WITH TAMOXIFEN OR AN AROMATASE INHIBITOR. COVERAGE FOR HR-POSITIVE, HER2- NEGATIVE ADVANCED OR METASTATIC BREAST CANCER REQUIRES COMBINATION THERAPY WITH AN AROMATASE INHIBITOR AS INITIAL ENDOCRINE BASED THERAPY. COVERAGE FOR HR-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER WITH DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY REQUIRES COMBINATION USE WITH FULVESTRANT. COVERAGE FOR THE TREATMENT OF ESTROGEN RECEPTOR (ER)-POSITIVE, HER2-NEGATIVE, ESTROGEN RECEPTOR-1 (ESR1)-MUTATED ADVANCED OR METASTATIC BREAST CANCER WITH DISEASE PROGRESSION FOLLOWING AT LEAST ONE LINE OF ENDOCRINE THERAPY REQUIRES COMBINATION USE WITH IMLUNESTRANT. COVERAGE AS MONOTHERAPY FOR THE TREATMENT OF ADULT PATIENTS WITH HR-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC CANCER WITH DISEASE PROGRESSION REQUIRES PRIOR ENDOCRINE AND CHEMOTHERAPY IN THE METASTATIC SETTING.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VIGABATRIN

Products Affected

- Vigabatrin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOQUEZNA

Products Affected

- Voquezna Dual Pak
- Voquezna Triple Pak

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE REQUIRES A DIAGNOSIS OF HELICOBACTER PYLORI (H. PYLORI) INFECTION.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF H. PYLORI INFECTION REQUIRES A TRIAL OF A GENERIC, GUIDELINE RECOMMENDED, FIRST-LINE REGIMEN FOR H. PYLORI INFECTION SUCH AS 1. CLARITHROMYCIN TRIPLE THERAPY (PROTON PUMP INHIBITOR (PPI) + CLARITHROMYCIN + AMOXICILLIN OR METRONIDAZOLE) OR 2. BISMUTH QUADRUPLE THERAPY (PPI + BISMUTH SUBCITRATE OR SUBSALICYLATE + TETRACYCLINE + METRONIDAZOLE).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VORANIGO

Products Affected

- Voranigo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE IS PROVIDED FOR TREATMENT OF GRADE 2 ASTROCYTOMA OR OLIGODENDROGLIOMA FOLLOWING SURGERY INCLUDING BIOPSY, SUB-TOTAL RESECTION, OR GROSS TOTAL RESECTION.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VORICONAZOLE

Products Affected

- Voriconazole INJ
- Voriconazole SUSR
- Voriconazole TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOTRIENT

Products Affected

- Pazopanib Hydrochloride

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ADVANCED TISSUE SARCOMA (STS) REQUIRES PREVIOUS TREATMENT WITH CHEMOTHERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

VOWST

Products Affected

- Vowst

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	60 DAYS
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

VOYDEYA

Products Affected

- Voydeya

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE FOR THE TREATMENT OF EXTRAVASCULAR HEMOLYSIS (EVH) WITH PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) REQUIRES THAT THE PATIENT MUST HAVE CLINICALLY SIGNIFICANT EVH DUE TO PNH WITH THE FOLLOWING: HEMOGLOBIN (HGB) LESS THAN OR EQUAL TO 9.5 G/DL AND ABSOLUTE RETICULOCYTE COUNT GREATER THAN OR EQUAL TO 120 × 10^9/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE TREATMENT OF EVH WITH PNH REQUIRES COMBINATION USE WITH SOLIRIS OR ULTOMIRIS ONLY.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year

Other Criteria	COVERAGE IS PROVIDED FOR A DIAGNOSIS OF PHEOCHROMOCYTOMA OR PARAGANGLIOMA (PPGL). COVERAGE FOR THE ADJUVANT TREATMENT OF ADULT PATIENTS WITH RENAL CELL CARCINOMA (RCC) WITH A CLEAR CELL COMPONENT AT INTERMEDIATE-HIGH OR HIGH RISK OF RECURRENCE FOLLOWING NEPHRECTOMY, OR FOLLOWING NEPHRECTOMY AND RESECTION OF METASTATIC LESIONS REQUIRES COMBINATION USE WITH PEMBROLIZUMAB OR PEMBROLIZUMAB AND BERAHYALURONIDASE ALFA-PMPH. COVERAGE FOR MONOTHERAPY TREATMENT OF ADULT PATIENTS WITH ADVANCED RENAL CELL CARCINOMA (RCC) WITH A CLEAR CELL COMPONENT REQUIRES PRIOR THERAPY WITH A PROGRAMMED DEATH RECEPTOR-1 (PD-1) OR PROGRAMMED DEATH-LIGAND 1 (PD-L1) INHIBITOR AND A VASCULAR ENDOTHELIAL GROWTH FACTOR TYROSINE KINASE INHIBITOR (VEGF-TKI). COVERAGE IS PROVIDED FOR A DIAGNOSIS OF VON HIPPEL LINDAU (VHL) DISEASE FOR PATIENTS WHO REQUIRE THERAPY FOR ASSOCIATED RENAL CELL CARCINOMA (RCC), CENTRAL NERVOUS SYSTEM (CNS) HEMANGIOBLASTOMAS, OR PANCREATIC NEUROENDOCRINE TUMORS (pNET), NOT REQUIRING IMMEDIATE SURGERY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WINREVAIR

Products Affected

- Winrevair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR A DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION REQUIRES A TRIAL OF BOTH OF THE FOLLOWING: 1) GENERIC SILDENAFIL OR TADALAFIL AND 2) GENERIC BOSENTAN OR AMBRISENTAN
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

WYOST

Products Affected

- Osenvelt
- Wyost

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XATMEP

Products Affected

- Xatmep

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	ACUTE LYMPHOBLASTIC LEUKEMIA (ALL): DIAGNOSIS OF ACUTE LYMPHOBLASTIC LEUKEMIA (ALL). POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA) (INITIAL): DIAGNOSIS OF ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS. TRIAL AND FAILURE, CONTRAINDICATION, OR INTOLERANCE TO ONE NONSTEROIDAL ANTIINFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN).
Age Restrictions	ALL: PATIENT IS 18 YEARS OF AGE OR YOUNGER. PJIA (INITIAL): PATIENT IS 18 YEARS OF AGE OR YOUNGER.
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XCOPRI

Products Affected

- Xcopri

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE REQUIRES THE TRIAL OF 2 GENERIC ANTICONVULSANTS.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XDEMVY

Products Affected

- Xdemvy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE FOR DEMODEX BLEPHARITIS REQUIRES CONFIRMATION OF DIAGNOSIS OF DEMODEX BLEPHARITIS VIA THE PRESENCE OF COLLARETTES UPON EXAMINATION WITH A SLIT LAMP.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XELJANZ

Products Affected

- Tofacitinib Citrate SOLN
- Tofacitinib Citrate TABS
- Tofacitinib Citrate Er

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE) OR WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR RHEUMATOID ARTHRITIS (RA) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND A TRIAL OF ONE DISEASE-MODIFYING ANTIRHEUMATIC DRUG (DMARD) [E.G., METHOTREXATE (RHEUMATREX/TREXALL), ARAVA (LEFLUNOMIDE), AZULFIDINE (SULFASALAZINE)]. COVERAGE FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (JIA) REQUIRES A DIAGNOSIS OF ACTIVE POLYARTICULAR JIA AND A TRIAL OF ONE OF THE FOLLOWING DMARDS: ARAVA (LEFLUNOMIDE) OR RHEUMATREX/TREXALL (METHOTREXATE). COVERAGE FOR PSORIATIC ARTHRITIS (PSA) REQUIRES A DIAGNOSIS OF ACTIVE PSA. COVERAGE FOR ANKYLOSING SPONDYLITIS (AS) REQUIRES A DIAGNOSIS OF ACTIVE AS AND A TRIAL OF ONE NONSTEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) (E.G., DICLOFENAC, IBUPROFEN, MELOXICAM, NAPROXEN). COVERAGE FOR ULCERATIVE COLITIS (UC) REQUIRES A DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE UC. FOR ALL INDICATIONS: COVERAGE ALSO REQUIRES AN INADEQUATE RESPONSE OR INTOLERANCE TO ONE OR MORE TNF INHIBITOR (E.G., ENBREL, ADALIMUMAB-AATY OR ADALIMUMAB-ADBM) OR DOCUMENTATION DEMONSTRATING THAT A TRIAL MAY BE INAPPROPRIATE. FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY AND THAT THE PATIENT IS NOT RECEIVING TOFACITINIB IN COMBINATION WITH A POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE, CYCLOSPORINE).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF CARCINOID SYNDROME DIARRHEA REQUIRES A TRIAL OF SOMATOSTATIN ANALOG (SSA) THERAPY (E.G., OCTREOTIDE, SOMATULINE).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XIFAXAN

Products Affected

- Xifaxan TABS 550MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR A DIAGNOSIS OF HEPATIC ENCEPHALOPATHY REQUIRES A TRIAL OF LACTULOSE. COVERAGE FOR IRRITABLE BOWEL SYNDROME WITH DIARRHEA REQUIRES TRIAL OF AT LEAST ONE OF THE FOLLOWING: LOPERAMIDE, DICYCLOMINE, OR DIPHENOXYLATE/ATROPINE. COVERAGE FOR RECURRENT CLOSTRIDIUM DIFFICILE DIARRHEA (C. DIFF) REQUIRES TRIAL OF VANCOMYCIN.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	CANNOT BE USED IN COMBINATION WITH ANOTHER BIOLOGIC OR TARGETED DMARD INDICATED FOR THE SAME CONDITION
Required Medical Information	ALLERGIC ASTHMA: IMMUNOGLOBULIN E (IGE) LEVEL GREATER THAN 30 AND LESS THAN 700 UNITS PER MILLILITER (IU/ML) FOR 12 YEARS AND OLDER, GREATER THAN 30 AND LESS THAN 1300 IU/ML FOR 6 YEARS THROUGH 12 YEARS CRSWNP: IMMUNOGLOBULIN E (IGE) LEVEL BETWEEN 30 AND 1500 IU/ML AT INITIATION OF TREATMENT
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR

Other Criteria	COVERAGE FOR UNCONTROLLED MODERATE TO SEVERE ALLERGIC ASTHMA REQUIRES DIAGNOSIS OF THIS CONDITION WITH A POSITIVE SKIN TEST OR IN VITRO REACTIVITY TO A PERENNIAL AEROALLEREN. COVERAGE FOR THIS CONDITION ALSO REQUIRES FAILURE TO MAINTAIN ADEQUATE CONTROL AFTER A TRIAL OF SYSTEMIC CORTICOSTEROIDS OR HIGH DOSE INHALED CORTICOSTEROIDS IN COMBINATION WITH A TRIAL OF ONE OF THE FOLLOWING ADDITIONAL ASTHMA CONTROLLER MEDICATIONS: LEUKOTRIENE MODIFIER (E.G. MONTELUKAST), LONG-ACTING BETA-2 AGONIST (LABA, E.G. SALMETEROL), OR LONG ACTING MUSCARINIC ANTAGONIST (LAMA, E.G. TIOTROPIUM) IN ADULTS AND CHILDREN 12 YEARS OF AGE OR OLDER. COVERAGE FOR CHRONIC SPONTANEOUS URTICARIA (CSU) REQUIRES DIAGNOSIS OF CSU AND SYMPTOMS DESPITE H1 ANTIHISTAMINE TREATMENT. COVERAGE FOR CSU ALSO REQUIRES A TRIAL OF AT LEAST ONE SECOND GENERATION ANTIHISTAMINE. COVERAGE FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES DIAGNOSIS OF CRSWNP AND RECURRING CRSWNP DESPITE PREVIOUS TREATMENT WITH INTRANASAL CORTICOSTEROIDS (E.G. FLUTICASONE, MOMETASONE). FOR ALL INDICATIONS, REAUTHORIZATION REQUIRES DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO THERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XPHOZAH

Products Affected

- Xphozah

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

XPOVIO

Products Affected

- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH MULTIPLE MYELOMA REQUIRES FAILURE OF ONE PRIOR THERAPY. COVERAGE FOR THE TREATMENT OF ADULT PATIENTS WITH RELAPSED OR REFRACTORY MULTIPLE MYELOMA REQUIRES TRIAL OF AT LEAST FOUR PRIOR THERAPIES (REFRACTORY TO AT LEAST TWO PROTEASOME INHIBITORS, AT LEAST TWO IMMUNOMODULATORY AGENTS, AND AN ANTI-CD38 MONOCLONAL ANTIBODY).
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR CASTRATION RESISTANT PROSTATE CANCER (CRPC), METASTATIC CASTRATION RESISTANT PROSTATE CANCER (MCRPC), METASTATIC CASTRATION SENSITIVE PROSTATE CANCER (MCSPC), AND HIGH-RISK NONMETASTATIC PROSTATE CANCER REQUIRE TRIAL OF ABIRATERONE, USING THE 250MG TABLET STRENGTH
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

XYREM

Products Affected

- Sodium Oxybate

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	COVERAGE IS NOT PROVIDED FOR PATIENTS TAKING SEDATIVE HYPNOTICS OR IN PATIENTS WITH SUCCINIC SEMIALDEHYDE DEHYDROGENASE DEFICIENCY.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES A DIAGNOSIS OF CATAPLEXY OR EXCESSIVE DAYTIME SLEEPINESS (EDS) WITH NARCOLPESY AND, IF 18 YEARS OF AGE OR OLDER, A TRIAL OF ARMODAFINIL AND SUNOSI
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE REQUIRES THE TRIAL OF ABIRATERONE 250 MG.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZARXIO

Products Affected

- Zarxio

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR ACUTE MYELOID LEUKEMIA (AML) REQUIRES PRIOR INDUCTION OR CONSOLIDATION CHEMOTHERAPY TREATMENT.
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZEJULA

Products Affected

- Zejula TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR THE MAINTENANCE TREATMENT OF ADULTS WITH ADVANCED EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER OR FOR THE MAINTENANCE TREATMENT OF ADULT PATIENTS WITH DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE BRCA-MUTATED RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER REQUIRES COMPLETE OR PARTIAL RESPONSE TO FIRST-LINE PLATINUM-BASED CHEMOTHERAPY.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZENBEXUS

Products Affected

- Zenbexus

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	COVERAGE FOR THE TREATMENT OF MULTIPLE MYELOMA REQUIRES BOTH OF THE FOLLOWING: 1) AT LEAST ONE PRIOR LINE OF THERAPY INCLUDING A PROTEASOME INHIBITOR AND AN IMMUNOMODULATORY AGENT AND 2) COMBINATION USE WITH DARATUMUMAB AND HYALURONIDASE-FIHJ AND DEXAMETHASONE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZEPZELCA

Products Affected

- Zepzelca

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	COVERAGE FOR THE MAINTENANCE TREATMENT OF EXTENSIVE-STAGE SCLC REQUIRES COMBINATION USE WITH ATEZOLIZUMAB OR ATEZOLIZUMAB AND HYALURONIDASE-TQIS AND CONFIRMATION THE PATIENT'S DISEASE HAS NOT PROGRESSED FOLLOWING FIRST-LINE INDUCTION THERAPY WITH ATEZOLIZUMAB OR ATEZOLIZUMAB AND HYALURONIDASE-TQIS, CARBOPLATIN AND ETOPOSIDE.
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	One Year
Other Criteria	COVERAGE FOR THE TREATMENT OF CUTANEOUS MANIFESTATIONS IN PATIENTS WITH CUTANEOUS T-CELL LYMPHOMA WHO HAVE PROGRESSIVE, PERSISTENT OR RECURRENT DISEASE REQUIRES TRIAL OF TWO SYSTEMIC THERAPIES
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZONISADE

Products Affected

- Zonisade

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	COVERAGE FOR THE TREATMENT OF SEIZURE DISORDER REQUIRES ONE OF THE FOLLOWING: 1. A TRIAL OF AT LEAST 2 GENERIC ANTICONVULSANTS, ONE OF WHICH MUST BE GENERIC ZONISAMIDE OR 2. PATIENT IS UNABLE TO SWALLOW TABLETS/CAPSULES
Prerequisite Therapy Required	Criteria DOES require use of a prerequisite Part D drug.

ZTALMY

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZURZUVAE

Products Affected

- Zurzuvae

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	COVERAGE FOR POSTPARTUM DEPRESSION (PPD) REQUIRES BOTH OF THE FOLLOWING: 1. A DIAGNOSIS OF PPD WITH AN ONSET OF DEPRESSIVE SYMPTOMS IN THE THIRD TRIMESTER OR WITHIN 4 WEEKS POSTPARTUM AND 2. MEMBER IS CURRENTLY LESS THAN OR EQUAL TO 12 MONTHS POSTPARTUM.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	60 Days
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

ZYKADIA

Products Affected

- Zykadia TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Prerequisite Therapy Required	Criteria DOES NOT require use of a prerequisite Part D drug.

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant
- Astagraf XL
- Azathioprine TABS 50MG
- Budesonide SUSP
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS
- Cyclosporine Modified
- Dronabinol CAPS
- Engerix-b
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Heplisav-b
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Ondansetron Hcl SOLN 4MG/5ML
- Ondansetron Hydrochloride TABS
- Ondansetron Odt TBDP 4MG, 8MG
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Prograf PACK
- Prosol
- Pulmozyme SOLN 2.5MG/2.5ML
- Rabavert
- Recombivax Hb
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tacrolimus Er
- Tobramycin NEBU 300MG/5ML
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Ventavis

Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

ABILIFY ASIMTUFII

Products Affected

- Abilify Asimtufii

Details

Criteria	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME

ABILIFY MAINTENA

Products Affected

- Abilify Maintena

Details

Criteria	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME.

ANTIDEPRESSANTS

Products Affected

- Exxua
- Exxua Titration Pack
- Trintellix

Details

Criteria	REQUIRES TRIAL OF AT LEAST 2 OF THE FOLLOWING GENERIC DRUGS: BUPROPION, CITALOPRAM, DESVENLAFAXINE, DULOXETINE, ESCITALOPRAM, FLUOXETINE, FLUVOXAMINE, MIRTAZAPINE, NEFAZODONE, PHENELZINE, PROTRIPTYLINE, SERTRALINE, TRANYLCYPROMINE, TRAZODONE, TRIMIPRAMINE, VENLAFAXINE, VILAZODONE. COVERAGE DURATION IS LIFETIME.

ANTIPSYCHOTIC AGENTS

Products Affected

- Caplyta
- Rexulti
- Vraylar CAPS
- Zyprexa Relprevv

Details

Criteria	REQUIRES TRIAL OF AT LEAST ONE OF THE FOLLOWING GENERIC DRUGS: ARIPIPRAZOLE, ASENAPINE, FLUPHENAZINE, HALOPERIDOL, LOXAPINE, LURASIDONE, MOLINDONE, OLANZAPINE INJECTION, PALIPERIDONE, PIMOZIDE, QUETIAPINE, RISPERIDONE, THIORIDAZINE, THIOTHIXENE, TRIFLUOPERAZINE, ZIPRASIDONE. COVERAGE DURATION IS LIFETIME.

ARISTADA

Products Affected

- Aristada

Details

Criteria	REQUIRES TRIAL OR INTOLERANCE TO ABILIFY MAINTENA OR ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME

ARISTADA INITIO

Products Affected

- Aristada Initio

Details

Criteria	REQUIRES TRIAL OF ORAL ARIPIPRAZOLE. COVERAGE DURATION IS LIFETIME.

INSULIN DELIVERY SUPPLIES

Products Affected

- Alcohol Prep Pads PADS 70%
- Curity Gauze Pads 2"x2" 12 Ply

Details

Criteria	COVERAGE REQUIRES A CLAIM FOR AN INSULIN PRODUCT IN THE LAST 180 DAYS. COVERAGE DURATION IS 1 YEAR.

INVEGA HAFYERA

Products Affected

- Invega Hafyera

Details

Criteria	REQUIRES TRIAL OF A ONCE-A MONTH PALIPERIDONE PALMITATE EXTENDED-RELEASE INJECTABLE SUSPENSION FOR AT LEAST 4 MONTHS OR AN EVERY-THREE-MONTH PALIPERIDONE PALMITATE EXTENDED -RELEASE INJECTABLE SUSPENSION FOR AT LEAST ONE THREE MONTH CYCLE. COVERAGE DURATION IS LIFETIME.

INVEGA SUSTENNA

Products Affected

- Invega Sustenna

Details

Criteria	REQUIRES TRIAL OF ORAL PALIPERIONE OR ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.

INVEGA TRINZA

Products Affected

- Invega Trinza

Details

Criteria	REQUIRES TRIAL OF ORAL PALIPERIDONE OR ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.

RHOPRESSA

Products Affected

- Rhopressa

Details

Criteria	COVERAGE REQUIRES TRIAL OF ONE OF THE FOLLOWING: ANY GENERIC FORMULARY OPHTHALMIC (EYE) GLAUCOMA MEDICATION OR LUMIGAN. COVERAGE DURATION IS 1 YEAR.

RISPERDAL CONSTA

Products Affected

- Risperidone Er

Details

Criteria	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.

ROCKLATAN

Products Affected

- Rocklatan

Details

Criteria	COVERAGE REQUIRES TRIAL OF ONE OF THE FOLLOWING: ANY GENERIC FORMULARY OPHTHALMIC (EYE) GLAUCOMA MEDICATION OR LUMIGAN. COVERAGE DURATION IS 1 YEAR.

RYKINDO

Products Affected

- Rykindo

Details

Criteria	REQUIRES TRIAL OF ORAL RISPERIDONE. COVERAGE DURATION IS LIFETIME.

RYTARY

Products Affected

- Rytary

Details

Criteria	COVERAGE REQUIRES TRIAL OF GENERIC ORAL EXTENDED-RELEASE CARBIDOPA & LEVODOPA. COVERAGE DURATION IS 1 YEAR.

SGLT2

Products Affected

- Jardiance

Details

Criteria	JARDIANCE: REQUIRES TRIAL OF GENERIC DAPAGLIFLOZIN. STEP THERAPY DOES NOT APPLY FOR REQUESTS FOR JARDIANCE WHEN BEING USED TO REDUCE THE RISK OF CARDIOVASCULAR DEATH IN ADULTS WITH TYPE 2 DIABETES MELLITUS AND ESTABLISHED CARDIOVASCULAR DISEASE.

ULORIC

Products Affected

- Febuxostat

Details

Criteria	REQUIRES TRIAL OR CONTRAINDICATION OF ALLOPURINOL. COVERAGE DURATION IS LIFETIME.