

Products Affected

- *adapalene 0.1% cream*
- *adapalene/benzoyl peroxide 0.1-2.5% gel*
- *tretinoin 0.025% cream*
- *tretinoin 0.05% cream*
- *adapalene 0.3% gel*
- *tretinoin 0.01% gel*
- *tretinoin 0.025% gel*
- *tretinoin 0.1% cream*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— ACTEMRA 162MG/0.9ML AUTO-INJECTOR

— ACTEMRA 162MG/0.9ML SYRINGE

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Enbrel, b) Humira, c) Rinvoq OR d) Xeljanz. For polyarticular juvenile idiopathic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira, b) Enbrel OR c) Xeljanz. For giant cell arteritis (all requests): Trial of other agents not required. For systemic sclerosis-associated interstitial lung disease (initial requests): a) Diagnosis is confirmed with documentation provided of both of the following: i) HRCT scan AND ii) pulmonary function tests AND b) Trial of mycophenolate was ineffective or not tolerated. For systemic juvenile idiopathic arthritis (all requests): Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, systemic juvenile idiopathic arthritis, and giant cell arteritis: Prescribed by, or in consultation with, a rheumatology specialist. For systemic sclerosis-associated interstitial lung disease: Prescribed by, or in consultation with, a pulmonologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– ACTIMMUNE 2000000UNIT/0.5ML INJ (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– ADBRY 150MG/ML SYRINGE

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For atopic dermatitis (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. |

Products Affected

— *alyq 20mg tab*

— *tadalafil 20mg tab*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Diagnosis confirmed by right heart catheterization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- ADEMPAS 0.5MG TAB
- ADEMPAS 1MG TAB
- ADEMPAS 2MG TAB

- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For all indications: Diagnosis confirmed by right heart catheterization. For pulmonary arterial hypertension: Both of the following were ineffective or not tolerated: one ERA (ambrisentan, bosentan or macitentan (Opsumit)) AND one PDE5-inhibitor (sildenafil or tadalafil). C) For persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4): Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- everolimus 10mg tab (New Starts Only)
- everolimus 2mg tab for oral susp (New Starts Only)
- everolimus 5mg tab (New Starts Only)
- everolimus 7.5mg tab (New Starts Only)
- everolimus 2.5mg tab (New Starts Only)
- everolimus 3mg tab for oral susp (New Starts Only)
- everolimus 5mg tab for oral susp (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– AIMOVIG 140MG/ML AUTO-INJECTOR

– AIMOVIG 70MG/ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) An 8-week or greater trial of two of the three following drug classes was ineffective or not tolerated: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of ALK-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— nitazoxanide 500mg tab

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For diarrhea due to giardiasis: One of the following was ineffective or not tolerated: a) metronidazole OR b) tinidazole. For diarrhea due to cryptosporidiosis: Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- ARALAST 1000MG INJ
- PROLASTIN 1000MG INJ

- GLASSIA 1000MG/50ML INJ
- ZEMAIRA 1000MG INJ

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | A) Diagnosis of congenital alpha 1-antitrypsin deficiency is confirmed by both of the following: a) circulating baseline alpha 1-antitrypsin level is below the standard protective threshold (less than 11 micromol/L OR less than 50 mg per deciliter by nephelometry) AND b) high risk alpha 1-antitrypsin deficiency genotype (SS, SZ, ZZ, or null/null) AND B) Prescriber attests that member does not have IgA deficiency with known anti-IgA antibody. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a pulmonologist |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- ALUNBRIG 180MG TAB (New Starts Only)
- ALUNBRIG 90MG TAB (New Starts Only)

- ALUNBRIG 30MG TAB (New Starts Only)
- ALUNBRIG INITIATION PACK (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of ALK-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- APTIOM 200MG TAB (New Starts Only)
- APTIOM 600MG TAB (New Starts Only)

- APTIOM 400MG TAB (New Starts Only)
- APTIOM 800MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– ARCALYST 220MG INJ

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– ARIKAYCE 590MG/8.4ML INH SUSP

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an infectious disease specialist or pulmonologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— AURYXIA 210MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- AUSTEDO 12MG ER TAB
- AUSTEDO 24MG ER TAB
- AUSTEDO 6MG TAB
- AUSTEDO XR ONCE DAILY 4 WEEK TITRATION PACK
- AUSTEDO 12MG TAB
- AUSTEDO 6MG ER TAB
- AUSTEDO 9MG TAB

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For tardive dyskinesia (initial requests): A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy OR iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy AND B) Member has a functional disability due to tardive dyskinesia. For chorea associated with Huntington's disease (initial requests): Trial of tetrabenazine was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist or psychiatrist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- AYVAKIT 100MG TAB (New Starts Only)
- AYVAKIT 25MG TAB (New Starts Only)
- AYVAKIT 50MG TAB (New Starts Only)
- AYVAKIT 200MG TAB (New Starts Only)
- AYVAKIT 300MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For unresectable or metastatic gastrointestinal stromal tumor: Documentation is provided of PDGFRA exon 18 mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- BALVERSA 3MG TAB (New Starts Only)
- BALVERSA 5MG TAB (New Starts Only)

- BALVERSA 4MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of susceptible FGFR2 or FGFR3 genetic alteration. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– BAXDELA 450MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for 6 months. |
| Other Criteria | |

Products Affected

– BENLYSTA 200MG/ML AUTO-INJECTOR

– BENLYSTA 200MG/ML SYRINGE

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For systemic lupus erythematosus initial requests: Two of the following were ineffective or not tolerated: a) hydroxychloroquine, b) methotrexate, c) azathioprine, d) mycophenolate OR e) a corticosteroid. For all requests: Prescriber attests that member does not have severe active CNS lupus AND member is not taking other biologics. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a rheumatology specialist, nephrologist, or dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For lupus erythematosus initial therapy: Diagnosis of active systemic lupus erythematosus is confirmed by one of the following: A) anti-double stranded DNA value greater than 30 IU/mL OR B) low complement (C3/C4) OR C) positive for anti-Smith antibodies. For systemic lupus erythematosus (all requests): Will not be given in combination with other biologics. For active lupus nephritis (all requests): Will not be used in combination with voclosporin (Lupkynis). |

Products Affected

– BESREMI 500MCG/ML SYRINGE (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | One of the following was ineffective or not tolerated: A) hydroxyurea OR B) peginterferon alfa-2a. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- BOSULIF 100MG TAB (New Starts Only)
- BOSULIF 500MG TAB (New Starts Only)

- BOSULIF 400MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— BRAFTOVI 75MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- BRIVIACT 100MG TAB (New Starts Only)
- BRIVIACT 10MG/ML ORAL SOLN (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)
- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 25MG TAB (New Starts Only)
- BRIVIACT 75MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— BRONCHITOL 40MG INH POWDER

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— BRUKINSA 80MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– BYDUREON 2MG/0.85ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– CABLIVI 11MG INJ

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | A) Member has received or will receive the first dose of caplacizumab while undergoing plasma exchange for acquired thrombotic thrombocytopenic purpura. B) Prescriber attests that patient will be monitored and therapy continued beyond 30 days post-plasma exchange only if ADAMTS23 levels remain less than 10%. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hematologist. |
| Coverage Duration | Approved for 4 months. |
| Other Criteria | |

Products Affected

- CABOMETYX 20MG TAB (New Starts Only)
- CABOMETYX 60MG TAB (New Starts Only)

- CABOMETYX 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- *calcipotriene 0.005% cream*
- *calcipotriene 0.005% topical soln*

- *calcipotriene 0.005% ointment*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– CALQUENCE 100MG CAP (New Starts Only)

– CALQUENCE 100MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- CAMZYOS 10MG CAP
- CAMZYOS 2.5MG CAP

- CAMZYOS 15MG CAP
- CAMZYOS 5MG CAP

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: Member is symptomatic despite a maximally tolerated dose of one of the following: a) a beta blocker OR b) a non-dihydropyridine calcium channel blocker. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a cardiologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- CAPLYTA 10.5MG CAP (New Starts Only)
- CAPLYTA 42MG CAP (New Starts Only)

- CAPLYTA 21MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For schizophrenia: Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone. For bipolar depression: Both of the following were ineffective or not tolerated: a) lurasidone AND b) quetiapine. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— CAPRELSA 100MG TAB (New Starts Only)

— CAPRELSA 300MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— *carglumic acid 200mg tab for oral susp*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– CAYSTON 75MG INH SOLN

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– CERDELGA 84MG CAP

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For all requests: Will not be used in combination with imiglucerase (Cerezyme) |

Products Affected

- CIBINQO 100MG TAB
- CIBINQO 50MG TAB

- CIBINQO 200MG TAB

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For atopic dermatitis (initial requests): Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant. For atopic dermatitis (continuation requests): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For atopic dermatitis (initial requests): Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For atopic dermatitis (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. |

Products Affected

– CIMZIA 200MG INJ

– CIMZIA 200MG/ML SYRINGE

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira, b) Enbrel c) Rinvoq OR d) Xeljanz. For ankylosing spondylitis (initial requests): Two of the following were ineffective or not tolerated: a) Humira, b) Enbrel, c) Taltz d) Rinvoq OR e) Xeljanz. For psoriatic arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira, b) Enbrel, c) Taltz, d) Stelara, e) Otezla, f) Skyrizi, g) Tremfya, h) Rinvoq OR i) Xeljanz. For plaque psoriasis (initial requests): Two of the following were ineffective or not tolerated: a) Humira, b) Enbrel, c) Taltz, d) Skyrizi, e) Stelara, f) Tremfya OR g) Otezla. For Crohn's disease (initial requests): Two of the following were ineffective or not tolerated: a) Humira, b) Stelara, c) Skyrizi, OR d) Rinvoq. For Non-radiographic axial spondyloarthritis (initial requests): Trial of two non-steroidal anti-inflammatory drugs (NSAIDs) was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For rheumatoid arthritis, psoriatic arthritis, non-radiographic axial spondyloarthritis or ankylosing spondylitis: Prescribed by, or in consultation, with a rheumatology specialist. For Crohn's disease: Prescribed by, or in consultation with, a gastroenterologist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- COMETRIQ CAP 100MG DAILY DOSE PACK (New Starts Only)
- COMETRIQ CAP 60MG DAILY DOSE PACK (New Starts Only)

- COMETRIQ CAP 140MG DAILY DOSE PACK (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— COPIKTRA 15MG CAP (New Starts Only)

— COPIKTRA 25MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- CORLANOR 5MG TAB
- CORLANOR 7.5MG TAB

- CORLANOR 5MG/5ML ORAL SOLN

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For adults (18 years and older), one of the following: A) Member is on a maximally tolerated dose of beta blocker OR B) Member has a history of intolerance, contraindication, or a hypersensitivity to beta blocker. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a cardiologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– COTELLIC 20MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For unresectable or metastatic melanoma: Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– CYSTADROPS 0.37% OPHTH SOLN

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– CYSTARAN 0.44% OPHTH SOLN

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– DAURISMO 100MG TAB (New Starts Only)

– DAURISMO 25MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- DIACOMIT 250MG CAP (New Starts Only)
- DIACOMIT 500MG CAP (New Starts Only)

- DIACOMIT 250MG POWDER FOR ORAL SUSP (New Starts Only)
- DIACOMIT 500MG POWDER FOR ORAL SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of at least one anti-epileptic medication was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– DIFICID 200MG TAB

– DIFICID 40MG/ML SUSP

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of oral vancomycin was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for 1 month. |
| Other Criteria | |

Products Affected

– DOJOLVI 100% ORAL SOLN

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: Diagnosis of a long-chain fatty acid oxidation disorder confirmed by two or more of the following: a) newborn blood screening/acylcarnitine profile b) molecular or genetic test OR c) fibroblast test. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a medical geneticist or prescriber specializing in the treatment of long-chain fatty acid oxidation disorders. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– DOPTELET 20MG TAB

– DOPTELET TAB 40MG DAILY DOSE PACK

– DOPTELET TAB 60MG DAILY DOSE PACK

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For thrombocytopenia with chronic liver disease and scheduled to undergo a procedure: Member has a platelet count from the prior two weeks that shows less than 50,000 platelets per microliter. For chronic immune thrombocytopenia initial requests: Both of the following: A) Relapsed or refractory to at least one prior treatment for chronic immune thrombocytopenia B) Platelet count less than 30,000 microliters. For chronic immune thrombocytopenia continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For chronic immune thrombocytopenia: Prescribed by, or in consultation with, a hematologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- DAYVIGO 10MG TAB
- QUVIVIQ 25MG

- DAYVIGO 5MG TAB
- QUVIVIQ 50MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Two of the following were ineffective or not tolerated: a) eszopiclone, b) ramelteon, c) zaleplon, or d) zolpidem. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- *dronabinol 10mg cap*
- *dronabinol 5mg cap*

- *dronabinol 2.5mg cap*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | Approval will be based off BvD coverage determination. |

Products Affected

- DUPIXENT 100MG/0.67ML SYRINGE
- DUPIXENT 200MG/1.14ML SYRINGE
- DUPIXENT 300MG/2ML SYRINGE
- DUPIXENT 200MG/1.14ML AUTO-INJECTOR
- DUPIXENT 300MG/2ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: For atopic dermatitis: Two of the following were ineffective or not tolerated: a) a medium to very high potency topical steroid, b) a topical calcineurin inhibitor OR c) an oral immunosuppressant (trial of other agents not required for patients under 2 years of age). For asthma: History, within the last year of at least 1 asthma exacerbation requiring one of the following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For nasal polyps: Both of the following were ineffective or not tolerated: a) an oral corticosteroid AND b) a nasal corticosteroid. For eosinophilic esophagitis: Trial of topical corticosteroid was ineffective or not tolerated. For prurigo nodularis: Trial of other agents not required. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For atopic dermatitis: Prescribed by, or in consultation with, an allergist, immunologist, or dermatologist. For asthma: Prescribed by, or in consultation with, an allergist, pulmonologist, or immunologist. For nasal polyps: Prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist. For eosinophilic esophagitis: Prescribed by, or in consultation with, an allergist or gastroenterologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For initial requests: For atopic dermatitis: Member has moderate to severe atopic dermatitis defined as: 1) One of the following: a) body surface area involvement of 10 percent or more OR b) Chart documentation is provided of severity with involvement of the face, head, neck, hands, feet, groin, or intertriginous areas. AND 2) At least two (2) of the following: a) intractable pruritus (itching), b) cracking and oozing/bleeding of skin OR c) impaired activities of daily living. For asthma: One of the following: 1) Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter) OR 2) Oral corticosteroid-dependent asthma requiring daily doses of 5 mg or greater prednisone (or equivalent). For nasal polyps, both of the following: A) Bilateral nasal polyposis confirmed with sinus CT scan AND B) Prescriber attests to moderate to severe symptoms of nasal congestion, blockage, or obstruction (such as loss of smell, rhinorrhea, or facial pain). For eosinophilic esophagitis, both of the following: A) endoscopic biopsy with at least 15 |

eosinophils per high-power field (hpf) AND B) symptoms of esophageal dysfunction (e.g. dysphagia). For prurigo nodularis: Both of the following apply: a) diagnosis has persisted for at least 6 weeks, AND b) at least 20 nodules present at baseline. For all indications (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication.

Products Affected

- EMGALITY 100MG/ML SYRINGE
- EMGALITY 120MG/ML SYRINGE

- EMGALITY 120MG/ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For migraine initial requests: Both of the following: A) Member has 4 or more migraine days per month for the previous 3 months or longer AND B) An 8-week or greater trial of two of the three following drug classes was ineffective or not tolerated: a) anticonvulsants, b) vasoactive agents, OR c) antidepressants. For episodic cluster headache prophylaxis initial requests: Trial of verapamil was ineffective or not tolerated. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- ENBREL 25MG/0.5ML INJ
- ENBREL 50MG/ML AUTO-INJECTOR
- ENBREL 50MG/ML SYRINGE
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML CARTRIDGE

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week required (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) acitretin (trial of other agents not required for patients under 18 years of age). For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For rheumatoid arthritis, psoriatic arthritis, juvenile idiopathic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis: Prescribed by, or in consultation with, a dermatologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— ENDARI 5GM POWDER FOR ORAL SOLN

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: Criteria 1 and 2 must be met or criteria 3 must be met: 1. Trial of a maximally tolerated hydroxyurea dose was ineffective or not tolerated. 2. Member has had at least 1 vaso-occlusive crisis in the prior 12 months, while on hydroxyurea (if applicable). 3. Prescriber is a hematologist. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hematologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– ENSPRYNG 120MG/ML SYRINGE

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of a positive test for anti-aquaporin-4 antibodies. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist, ophthalmologist, or neuro-ophthalmologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For all requests: Will not be used in combination with eculizumab (Soliris) or inebilizumab (Uplizna). |

Products Affected

– SOFOSBUVIR/VELPATASVIR 400-100MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | 1) Current HCV-RNA titer is provided 2) No prior treatment with a direct-acting antiviral for hepatitis C. 3) One of the following: a) Member does not have cirrhosis OR b) Member has compensated cirrhosis AND one of the following: i) Does not have genotype 3 OR ii) has genotype 3 but no NS5A resistance-associated substitution Y93H. OR c) Member has decompensated cirrhosis AND will receive weight-based ribavirin |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease or transplant specialist. |
| Coverage Duration | Coverage duration of 12 to 24 weeks. Applied consistent with current AASLD-IDSA guidance. |
| Other Criteria | |

Products Affected

– EPIDIOLEX 100MG/ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of at least one anti-epileptic medication was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— ERIVEDGE 150MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— ERLEADA 240MG TAB (New Starts Only)

— ERLEADA 60MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For metastatic castration-sensitive prostate cancer: Trial of abiraterone was ineffective or not tolerated. For nonmetastatic castration-resistant prostate cancer: Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- *pirfenidone 267mg cap*
- *pirfenidone 801mg tab*

- *pirfenidone 267mg tab*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For idiopathic pulmonary fibrosis initial requests: Diagnosis confirmed by one of the following: 1) Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) 2) High-resolution computed tomography indicates definite UIP pattern 3) Both High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– EVRYSDI 0.75MG/ML ORAL SOLN

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of a genetic test confirming diagnosis of spinal muscular atrophy. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For all requests: Will not be used in combination with nusinersen (Spinraza). |

Products Affected

– EXKIVITY 40MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of EGFR exon 20 insertion mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- FANAPT 10MG TAB (New Starts Only)
- FANAPT 1MG TAB (New Starts Only)
- FANAPT 4MG TAB (New Starts Only)
- FANAPT 8MG TAB (New Starts Only)
- FANAPT 12MG TAB (New Starts Only)
- FANAPT 2MG TAB (New Starts Only)
- FANAPT 6MG TAB (New Starts Only)
- FANAPT TITRATION PACK (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Two of the following were ineffective or not tolerated: a) aripiprazole, b) olanzapine, c) quetiapine, d) risperidone, e) ziprasidone, OR f) lurasidone. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— FASENRA 30MG/ML AUTO-INJECTOR

— FASENRA 30MG/ML SYRINGE

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: History within the last year of at least 1 asthma exacerbation requiring one of following, despite regular use of inhaled corticosteroids plus an additional controller(s): a) treatment with systemic corticosteroids, b) emergency department visit OR c) hospitalization. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For asthma: Prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For asthma (initial requests): Eosinophilic phenotype with baseline blood eosinophil concentration greater than or equal to 150 cells/microliter. For asthma (all requests): Will not be used in combination with another targeted immunomodulator product for the prescribed indication. |

Products Affected

— *deferiprone 1000mg tab*

— *deferiprone 500mg tab*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– FILSPARI 200MG TAB

– FILSPARI 400MG TAB

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: 1) Diagnosis confirmed with a kidney biopsy and 2) Member unable to adequately control proteinuria with ACE inhibitor or angiotensin receptor blocker therapy alone. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a nephrologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– FINTEPLA 2.2MG/ML ORAL SOLN (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of at least one anti-epileptic medication was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– FIRDAPSE 10MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by a neurologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by one of the following: a) Presence of voltage-gated calcium channel antibodies OR b) electrophysiologic compound muscle action potential test findings are consistent with LEMS. |

Products Affected

— FIRMAGON 120MG/VIAL INJ (New Starts Only)

— FIRMAGON 80MG INJ (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– DICLOFENAC EPOLAMINE 1.3% PATCH

– FLECTOR 1.3% PATCH

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— FOTIVDA 0.89MG CAP (New Starts Only)

— FOTIVDA 1.34MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- FYCOMPA 0.5MG/ML SUSP (New Starts Only)
- FYCOMPA 12MG TAB (New Starts Only)
- FYCOMPA 4MG TAB (New Starts Only)
- FYCOMPA 8MG TAB (New Starts Only)
- FYCOMPA 10MG TAB (New Starts Only)
- FYCOMPA 2MG TAB (New Starts Only)
- FYCOMPA 6MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For partial-onset seizures: Both of the following were ineffective or not tolerated: a) topiramate AND b) lacosamide. For primary generalized tonic-clonic seizures: Two of the following were ineffective or not tolerated: a) lamotrigine, b) levetiracetam, c) primidone OR d) topiramate. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist or epilepsy specialist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— GALAFOLD 123MG 28 DAY PACK

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided that member has an amenable galactosidase alpha gene (GLA) variant. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a medical geneticist, nephrologist or a prescriber specialized in the treatment of Fabry disease. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– GATTEX 5MG INJ

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Member is dependent on parenteral support for at least 12 months and at least 3 days per week. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– GAVRETO 100MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of RET gene fusion. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– GEMTESA 75MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Both of the following were ineffective or not tolerated: a) Myrbetriq AND b) one antimuscarinic agent. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- GILOTRIF 20MG TAB (New Starts Only)
- GILOTRIF 40MG TAB (New Starts Only)

- GILOTRIF 30MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of appropriate EGFR mutation. For squamous non-small cell lung cancer: Documentation of EGFR mutation not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- SKYTROFA 11MG CARTRIDGE
- SKYTROFA 3.6MG CARTRIDGE
- SKYTROFA 4.3MG CARTRIDGE
- SKYTROFA 6.3MG CARTRIDGE
- SKYTROFA 9.1MG CARTRIDGE
- SKYTROFA 13.3MG CARTRIDGE
- SKYTROFA 3MG CARTRIDGE
- SKYTROFA 5.2MG CARTRIDGE
- SKYTROFA 7.6MG CARTRIDGE

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Both of the following were ineffective or not tolerated: a) Omnitrope and b) Norditropin AND 2) Documentation is provided of failure to stimulate growth hormone secretion (peak growth hormone level of 10mcg/L or less) by one of the acceptable provocative tests. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- NORDITROPIN 10MG/1.5ML PEN INJ
- NORDITROPIN 30MG/3ML PEN INJ
- OMNITROPE 10MG/1.5ML CARTRIDGE
- OMNITROPE 5MG/1.5ML CARTRIDGE
- NORDITROPIN 15MG/1.5ML PEN INJ
- NORDITROPIN 5MG/1.5ML PEN INJ
- OMNITROPE 5.8MG INJ

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of failure to stimulate growth hormone secretion (peak growth hormone level of 10mcg/L or less) by one of the acceptable provocative tests. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- BERINERT 500UNIT INJ
 - HAEGARDA 2000UNIT INJ
 - *icatibant 10mg/ml syringe*
 - ORLADEYO 150MG CAP
 - *sajazir 30mg/3ml syringe*
 - TAKHZYRO 300MG/2ML SYRINGE
- CINRYZE 500UNIT INJ
 - HAEGARDA 3000UNIT INJ
 - ORLADEYO 110MG CAP
 - RUCONEST 2100UNIT INJ
 - TAKHZYRO 300MG/2ML INJ

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— *tasimelteon 20mg cap*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For non-24-hour sleep-wake disorder: Member is totally blind. For Smith-Magenis syndrome: Diagnosis of nighttime sleep disturbances in Smith-Magenis syndrome. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist or sleep specialist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- HUMIRA 10MG/0.1ML SYRINGE
- HUMIRA 40MG/0.4ML AUTO-INJECTOR
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA 80MG/0.8ML AUTO-INJECTOR
- HUMIRA PEN - CROHN'S STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - PEDIATRIC UC STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN 80MG/0.8ML AND 40MG/0.4ML - PSORIASIS/UVEITIS
- HUMIRA 20MG/0.2ML SYRINGE
- HUMIRA 40MG/0.4ML SYRINGE
- HUMIRA 40MG/0.8ML SYRINGE
- HUMIRA PEDIATRIC CROHN'S STARTER PACK SYRINGE (2) 40MC
- HUMIRA PEN - CROHN'S STARTER PACK 80MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 40MG/0.8ML
- HUMIRA PREFILLED SYRINGE 80MG/0.8ML STARTER PACK - PEC

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For rheumatoid arthritis (initial requests): Trial of methotrexate at a dose of at least 20mg/week (or maximally tolerated dose) was ineffective or not tolerated. For juvenile idiopathic arthritis (initial requests): Trial of methotrexate at a dose of at least 15 mg/week (or maximally tolerated dose) was ineffective or not tolerated. For plaque psoriasis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate at a dose of at least 15mg/week (or maximally tolerated dose) OR b) acitretin. For ankylosing spondylitis (AS)(initial requests): Trial of sulfasalazine was ineffective or not tolerated (Trial of sulfasalazine not required for AS with predominant axial involvement). For psoriatic arthritis (initial requests): One of the following was ineffective or not tolerated: a) methotrexate OR b) sulfasalazine. For ulcerative colitis or Crohn's disease (all requests): Trial of other agents not required. For hidradenitis suppurativa (initial requests): Member must have both of the following: a) At least 3 cysts AND b) Trial of one oral antibiotic was ineffective or not tolerated. For uveitis (initial requests): Both of the following were ineffective or not tolerated: a) a corticosteroid AND b) an immunosuppressant (methotrexate or cyclosporine). For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For rheumatoid arthritis, psoriatic arthritis, juvenile idiopathic arthritis or ankylosing spondylitis: Prescribed by, or in consultation with, a rheumatology specialist. For plaque psoriasis and hidradenitis suppurativa: Prescribed by, or in consultation with, a dermatologist. For Crohn's disease and ulcerative colitis: Prescribed by, or in consultation with, a gastroenterologist. For uveitis: Prescribed by, or in consult with, a rheumatology specialist OR ophthalmologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- IBRANCE 100MG CAP (New Starts Only)
- IBRANCE 125MG CAP (New Starts Only)
- IBRANCE 75MG CAP (New Starts Only)
- IBRANCE 100MG TAB (New Starts Only)
- IBRANCE 125MG TAB (New Starts Only)
- IBRANCE 75MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Intolerance or contraindication to therapy with both of the following: a) Verzenio AND b) Kisqali. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- ICLUSIG 10MG TAB (New Starts Only)
- ICLUSIG 30MG TAB (New Starts Only)

- ICLUSIG 15MG TAB (New Starts Only)
- ICLUSIG 45MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— IDHIFA 100MG TAB (New Starts Only)

— IDHIFA 50MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of IDH2 mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- ABILIFY 300MG INJ (New Starts Only)
- ABILIFY 400MG INJ (New Starts Only)
- ARISTADA 1064MG/3.9ML SYRINGE (New Starts Only)
- ARISTADA 662MG/2.4ML SYRINGE (New Starts Only)
- ARISTADA 882MG/3.2ML SYRINGE (New Starts Only)
- INVEGA 117MG/0.75ML SYRINGE (New Starts Only)
- INVEGA 156MG/ML SYRINGE (New Starts Only)
- INVEGA 273MG/0.875ML SYRINGE (New Starts Only)
- INVEGA 410MG/1.315ML SYRINGE (New Starts Only)
- INVEGA 78MG/0.5ML SYRINGE (New Starts Only)
- RISPERDAL 12.5MG INJ (New Starts Only)
- RISPERDAL 37.5MG INJ (New Starts Only)
- ABILIFY 300MG SYRINGE (New Starts Only)
- ABILIFY 400MG SYRINGE (New Starts Only)
- ARISTADA 441MG/1.6ML SYRINGE (New Starts Only)
- ARISTADA 675MG/2.4ML SYRINGE (New Starts Only)
- INVEGA 1092MG/3.5ML SYRINGE (New Starts Only)
- INVEGA 1560MG/5ML SYRINGE (New Starts Only)
- INVEGA 234MG/1.5ML SYRINGE (New Starts Only)
- INVEGA 39MG/0.25ML SYRINGE (New Starts Only)
- INVEGA 546MG/1.75ML SYRINGE (New Starts Only)
- INVEGA 819MG/2.625ML SYRINGE (New Starts Only)
- RISPERDAL 25MG INJ (New Starts Only)
- RISPERDAL 50MG INJ (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Patient has established tolerability with the oral version of medication being requested. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- IMBRUVICA 140MG CAP (New Starts Only)
- IMBRUVICA 70MG CAP (New Starts Only)

- IMBRUVICA 420MG TAB (New Starts Only)
- IMBRUVICA 70MG/ML SUSP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– INCRELEX 40MG/4ML INJ

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- INGREZZA 40MG CAP
- INGREZZA 80MG CAP

- INGREZZA 60MG CAP
- INGREZZA CAP PACK

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: A) One of the following: i) Member has failed to respond to a change in current antidopaminergic therapy OR ii) Member is unable to switch current antidopaminergic therapy OR iii) Member has symptoms of tardive dyskinesia and is not using antidopaminergic therapy AND B) Member has a functional disability due to tardive dyskinesia. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a neurologist or psychiatrist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– INLYTA 1MG TAB (New Starts Only)

– INLYTA 5MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– INQOVI 5 TABLET PACK (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– INREBIC 100MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of Jakafi was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— *gefitinib 250mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of appropriate EGFR mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- ISTURISA 10MG TAB
- ISTURISA 5MG TAB

- ISTURISA 1MG TAB

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: Trial of ketoconazole was ineffective or not tolerated. For continuation requests: Documentation is provided of urinary cortisol levels that show a positive clinical response. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, an endocrinologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— ivermectin 3mg tab

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for 1 month. |
| Other Criteria | |

Products Affected

- BIVIGAM 5GM/50ML INJ
- GAMMAGARD 10GM INJ
- GAMMAGARD 5GM INJ
- GAMMAPLEX 10GM/100ML INJ
- GAMMAPLEX 20GM/200ML INJ
- GAMUNEX 1GM/10ML INJ
- OCTAGAM 2GM/20ML INJ
- PANZYGA 1GM/10ML INJ
- PANZYGA 20GM/200ML INJ
- PANZYGA 5GM/50ML INJ
- FLEBOGAMMA 5GM/50ML INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAKED 1GM/10ML INJ
- GAMMAPLEX 10GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- OCTAGAM 1GM/20ML INJ
- PANZYGA 10GM/100ML INJ
- PANZYGA 2.5GM/25ML INJ
- PANZYGA 30GM/300ML INJ
- PRIVIGEN 20GM/200ML INJ

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | Approval will be based off BvD coverage determination. |

Products Affected

- JAKAFI 10MG TAB (New Starts Only)
- JAKAFI 20MG TAB (New Starts Only)
- JAKAFI 5MG TAB (New Starts Only)
- JAKAFI 15MG TAB (New Starts Only)
- JAKAFI 25MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– JAYPIRCA 100MG TAB (New Starts Only)

– JAYPIRCA 50MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- KALYDECO 13.4MG GRANULES
- KALYDECO 25MG GRANULES
- KALYDECO 75MG GRANULES

- KALYDECO 150MG TAB
- KALYDECO 50MG GRANULES

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— KERENDIA 10MG TAB

— KERENDIA 20MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of Farxiga was ineffective or not tolerated |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- KEVZARA 150MG/1.14ML AUTO-INJECTOR
- KEVZARA 200MG/1.14ML AUTO-INJECTOR

- KEVZARA 150MG/1.14ML SYRINGE
- KEVZARA 200MG/1.14ML SYRINGE

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For rheumatoid arthritis (initial requests): Two of the following were ineffective or not tolerated: a) Humira, b) Enbrel, c) Rinvoq OR d) Xeljanz. For polymyalgia rheumatica (initial requests), one of the following: a) a trial of a corticosteroid was ineffective OR b) member was unable to tolerate a corticosteroid taper to less than or equal to 5 mg prednisone equivalent per day. For continuation requests (all diagnoses): Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | For rheumatoid arthritis and polymyalgia rheumatica: Prescribed by, or in consultation with, a rheumatology specialist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- KISQALI 200MG DAILY DOSE PACK (21) (New Starts Only)
- KISQALI 600MG DAILY DOSE PACK (63) (New Starts Only)
- KISQALI/FEMARA 400 CO-PACK (New Starts Only)

- KISQALI 400MG DAILY DOSE PACK (42) (New Starts Only)
- KISQALI/FEMARA 200 CO-PACK (New Starts Only)
- KISQALI/FEMARA 600 CO-PACK (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– KORLYM 300MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– KOSELUGO 10MG CAP (New Starts Only)

– KOSELUGO 25MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Chart notes documentation is provided that indicates inoperable and symptomatic disease |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– KRAZATI 200MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of KRAS G12C mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- *javygtor 100mg powder for oral soln*
- *javygtor 500mg powder for oral soln*
- *sapropterin 100mg tab*

- *javygtor 100mg tab*
- *sapropterin 100mg powder for oral soln*
- *sapropterin 500mg powder for oral soln*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For continuation therapy: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a medical geneticist or metabolic physician. |
| Coverage Duration | Initial approval of 3 months. Continuing therapy approved for 1 year. |
| Other Criteria | |

Products Affected

- LENVIMA 10MG DAILY DOSE PACK (New Starts Only)
- LENVIMA 14MG DAILY DOSE PACK (New Starts Only)
- LENVIMA 20MG DAILY DOSE PACK (New Starts Only)
- LENVIMA 4MG DAILY DOSE PACK (New Starts Only)
- LENVIMA 12MG DAILY DOSE PACK (New Starts Only)
- LENVIMA 18MG DAILY DOSE PACK (New Starts Only)
- LENVIMA 24MG DAILY DOSE PACK (New Starts Only)
- LENVIMA 8MG DAILY DOSE PACK (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— *ambrisentan 10mg tab*

— *ambrisentan 5mg tab*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Diagnosis confirmed by right heart catheterization. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— lidocaine 5% patch

| PA Criteria | Criteria Details |
|------------------------|-------------------------------------|
| Covered Uses | All Medically-accepted Indications. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— lidocaine 5% ointment

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- LINZESS 145MCG CAP
- LINZESS 72MCG CAP

- LINZESS 290MCG CAP

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For irritable bowel syndrome with constipation and chronic idiopathic constipation: Both of the following were ineffective or not tolerated: A) Trulance AND B) lubiprostone. Trial of lubiprostone not required for adult male patients with irritable bowel syndrome with constipation. For functional constipation in patients aged 6 to 17 years: Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– LIVTENCITY 200MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Prescriber attests that the medication will not be used for CMV infection prophylaxis. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a hematologist, oncologist, transplant or infectious disease specialist. |
| Coverage Duration | Approved for 3 months. |
| Other Criteria | |

Products Affected

– LOKELMA 10GM POWDER FOR ORAL SUSP

– LOKELMA 5GM POWDER FOR ORAL SUSP

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: Member has baseline persistent potassium level greater than 5.0 mmol/L. For continuing requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a nephrologist, cardiologist, hematologist or endocrinologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— LONSURF 6.14-15MG TAB (New Starts Only)

— LONSURF 8.19-20MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— LORBRENA 100MG TAB (New Starts Only)

— LORBRENA 25MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of ALK-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– LUCEMYRA 0.18MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of clonidine was ineffective or not tolerated |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a prescriber specializing in pain management or addiction treatment. |
| Coverage Duration | Approved for 1 month. |
| Other Criteria | If member was initiated on lofexidine at an inpatient facility and request is for continuing therapy for up to a total of 14 days, prescriber and medical restrictions not required. |

Products Affected

– LUMAKRAS 120MG TAB (New Starts Only)

– LUMAKRAS 320MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of KRAS G12C mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- LUMRYZ 4.5GM GRANULES FOR ORAL SUSP
- LUMRYZ 7.5GM GRANULES FOR ORAL SUSP

- LUMRYZ 6GM GRANULES FOR ORAL SUSP
- LUMRYZ 9GM GRANULES FOR ORAL SUSP

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For excessive daytime sleepiness with narcolepsy in adults: Both of the following were ineffective or not tolerated: a) Sunosi AND b) either modafinil or armodafinil. For cataplexy with narcolepsy: Trial of other agents not required. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For excessive daytime sleepiness with narcolepsy: Documentation is provided of full nocturnal polysomnogram used to confirm diagnosis. For cataplexy with narcolepsy: Documentation is provided of one of the following to confirm diagnosis: a) full nocturnal polysomnogram OR b) low cerebrospinal fluid orexin-A concentration. |

Products Affected

– LUPKYNIS 7.9MG CAP

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For continuation therapy: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a rheumatology specialist or nephrologist. |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | For all requests: Will not be used in combination with belimumab (Benlysta). |

Products Affected

— LYNPARZA 100MG TAB (New Starts Only)

— LYNPARZA 150MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- LYTGOBI 4MG TAB PACK (12MG DAILY DOSE) (New Starts Only)
- LYTGOBI 4MG TAB PACK (16MG DAILY DOSE) (New Starts Only)
- LYTGOBI 4MG TAB PACK (20MG DAILY DOSE) (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of FGFR2 fusion or other rearrangement |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— MAVYRET 100-40MG TAB

— MAVYRET 50-20MG ORAL PELLETT

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | 1) Current HCV-RNA titer is provided 2) Member does not have decompensated cirrhosis 3) One of the following: a) no prior treatment with a direct-acting antiviral for hepatitis C, OR b) prior treatment with sofosbuvir-based regimen and all of the following: i) Member does not have genotype 3 AND ii) No prior treatment with an NS3/4A protease inhibitor. |
| Age Restrictions | |
| Prescriber Restriction | Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease or transplant specialist. |
| Coverage Duration | Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance. |
| Other Criteria | |

Products Affected

— *megestrol acetate 125mg/ml susp*

— *megestrol acetate 40mg/ml susp*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— *megestrol acetate 20mg tab (New Starts Only)*

— *megestrol acetate 40mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- MEKINIST 0.05MG/ML ORAL SOLN (New Starts Only)
- MEKINIST 2MG TAB (New Starts Only)

- MEKINIST 0.5MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– MEKTOVI 15MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of appropriate BRAF V600E or V600K mutation. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— *dihydroergotamine mesylate 0.5mg/act nasal inhaler*

| PA Criteria | Criteria Details |
|------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of two different triptans was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— MOTTEGRITY 1MG TAB

— MOTTEGRITY 2MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Trial of Trulance was ineffective or not tolerated. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- MOUNJARO 10MG/0.5ML AUTO-INJECTOR
- MOUNJARO 15MG/0.5ML AUTO-INJECTOR
- MOUNJARO 5MG/0.5ML AUTO-INJECTOR

- MOUNJARO 12.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 2.5MG/0.5ML AUTO-INJECTOR
- MOUNJARO 7.5MG/0.5ML AUTO-INJECTOR

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— MOVANTIK 12.5MG TAB

— MOVANTIK 25MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- *carisoprodol 350mg tab*
- *cyclobenzaprine 10mg tab*
- *metaxalone 800mg tab*
- *methocarbamol 750mg tab*
- *chlorzoxazone 500mg tab*
- *cyclobenzaprine 5mg tab*
- *methocarbamol 500mg tab*
- *orphenadrine citrate 100mg er tab*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | Prior Authorization applies to patients 65 years or older. |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 200mg/ml inh soln*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 1.25mg/3ml neb soln*
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg/aprepitant 80mg cap therapy pack*
- *aprepitant 80mg cap*
- *azathioprine 50mg tab*
- *budesonide 0.25mg/ml inh susp*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/5 INJ
- CLINIMIX E 5/20 INJ
- CYCLOPHOSPHAMIDE 25MG TAB
- *cyclosporine 100mg cap*
- *cyclosporine modified 100mg cap*
- *cyclosporine modified 25mg cap*
- DIPHTHERIA/TETANUS TOXOID INJ
- ENGERIX-B 20MCG/ML INJ
- ENVARUSUS XR 0.75MG TAB
- ENVARUSUS XR 4MG TAB
- *everolimus 0.5mg tab*
- *everolimus 1mg tab*
- *gengraf 100mg cap*
- *gengraf 25mg cap*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 2MG/ML INJ
- *granisetron 1mg tab*
- HUMULIN R 500UNIT/ML INJ
- *acetylcysteine 100mg/ml inh soln*
- *acyclovir 50mg/ml inj*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- ALBUTEROL 5MG/ML INH SOLN
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- *arformoterol tartrate 15mcg/2ml neb soln*
- *budesonide 0.125mg/ml inh susp*
- *budesonide 0.5mg/ml inh susp*
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 5/15 INJ
- *clinisol 15 inj*
- CYCLOPHOSPHAMIDE 50MG TAB
- *cyclosporine 25mg cap*
- *cyclosporine modified 100mg/ml oral soln*
- *cyclosporine modified 50mg cap*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARUSUS XR 1MG TAB
- *everolimus 0.25mg tab*
- *everolimus 0.75mg tab*
- *formoterol fumarate 20mcg/2ml neb soln*
- *gengraf 100mg/ml oral soln*
- *glucose 100mg/ml inj*
- GLUCOSE 100MG/ML/SODIUM CHLORIDE 4.5MG/ML INJ
- HEPLISAV-B 20MCG/0.5ML SYRINGE
- IMOVAX 2.5UNIT/ML INJ

- INSULIN LISPRO 100UNIT/ML INJ
- INTRALIPID 30GM/100ML INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol 0.63mg/3ml inh soln*
- *levalbuterol 1.25mg/3ml neb soln*
- *methylprednisolone 32mg tab*
- *methylprednisolone 8mg tab*
- *mycophenolate mofetil 250mg cap*
- *mycophenolic acid 180mg dr tab*
- NUTRILIPID 20GM/100ML INJ
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pentamidine isethionate 50mg/ml inh soln*
- *prednisolone 1mg/ml oral soln*
- *prednisolone 4mg/ml oral soln*
- *prednisone 10mg tab*
- PREDNISON 1MG/ML ORAL SOLN
- *prednisone 20mg tab*
- *prednisone 5mg tab*
- PREMASOL 10% INJ
- PROGRAF 1MG GRANULES FOR ORAL SUSP
- PULMOZYME 1MG/ML INH SOLN
- RECOMBIVAX 10MCG/ML INJ
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- *sirolimus 0.5mg tab*
- *sirolimus 1mg/ml oral soln*
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TENIVAC 4-10UNIT/ML INJ
- INTRALIPID 20GM/100ML INJ
- *ipratropium bromide 0.02% inh soln*
- *levalbuterol 0.31mg/3ml neb soln*
- *levalbuterol 1.25mg/0.5ml neb soln*
- *methylprednisolone 16mg tab*
- *methylprednisolone 4mg tab*
- *mycophenolate mofetil 200mg/ml susp*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- *plenamine 15% inj*
- *prednisolone 3mg/ml oral soln*
- *prednisolone 5mg/ml oral soln*
- *prednisone 1mg tab*
- *prednisone 2.5mg tab*
- *prednisone 50mg tab*
- PREHEVBRIO 10MCG/ML INJ
- PROGRAF 0.2MG GRANULES FOR ORAL SUSP
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- *sirolimus 1mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*
- TDVAX 4-4UNIT/ML INJ
- TENIVAC 4-10UNIT/ML SYRINGE

- TPN ELECTROLYTES INJ
- TROPHAMINE 10% INJ

- TRAVASOL 10% INJ
- VARUBI 90MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | 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. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | |
| Other Criteria | |

Products Affected

- NATPARA 100MCG CARTRIDGE
- NATPARA 50MCG CARTRIDGE

- NATPARA 25MCG CARTRIDGE
- NATPARA 75MCG CARTRIDGE

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— NERLYNX 40MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— *sorafenib 200mg tab (New Starts Only)*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— NEXLETOL 180MG TAB

— NEXLIZET 180-10MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For initial requests: One of the following: a) Current LDL-C level is greater than or equal to 70 mg/dL while on ezetimibe and a maximally tolerated statin OR b) Current LDL-C level is greater than or equal to 70 mg/dL AND member is statin intolerant. For continuation requests: Member has benefited with use of this medication. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- NINLARO 2.3MG CAP (New Starts Only)
- NINLARO 4MG CAP (New Starts Only)

- NINLARO 3MG CAP (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

- *droxidopa 100mg cap*
- *droxidopa 300mg cap*

- *droxidopa 200mg cap*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— NOURIANZ 20MG TAB

— NOURIANZ 40MG TAB

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | One agent from both of the following classes was ineffective or not tolerated: a) COMT inhibitor AND b) MAO-B inhibitor. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

— NOXAFIL 300MG POWDER FOR ORAL SUSP

— *posaconazole 100mg dr tab*

— *posaconazole 40mg/ml susp*

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |

Products Affected

– ZYKADIA 150MG TAB (New Starts Only)

| PA Criteria | Criteria Details |
|------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Documentation is provided of ALK-positive disease. |
| Age Restrictions | |
| Prescriber Restriction | |
| Coverage Duration | Approved for duration of 1 year. |
| Other Criteria | |