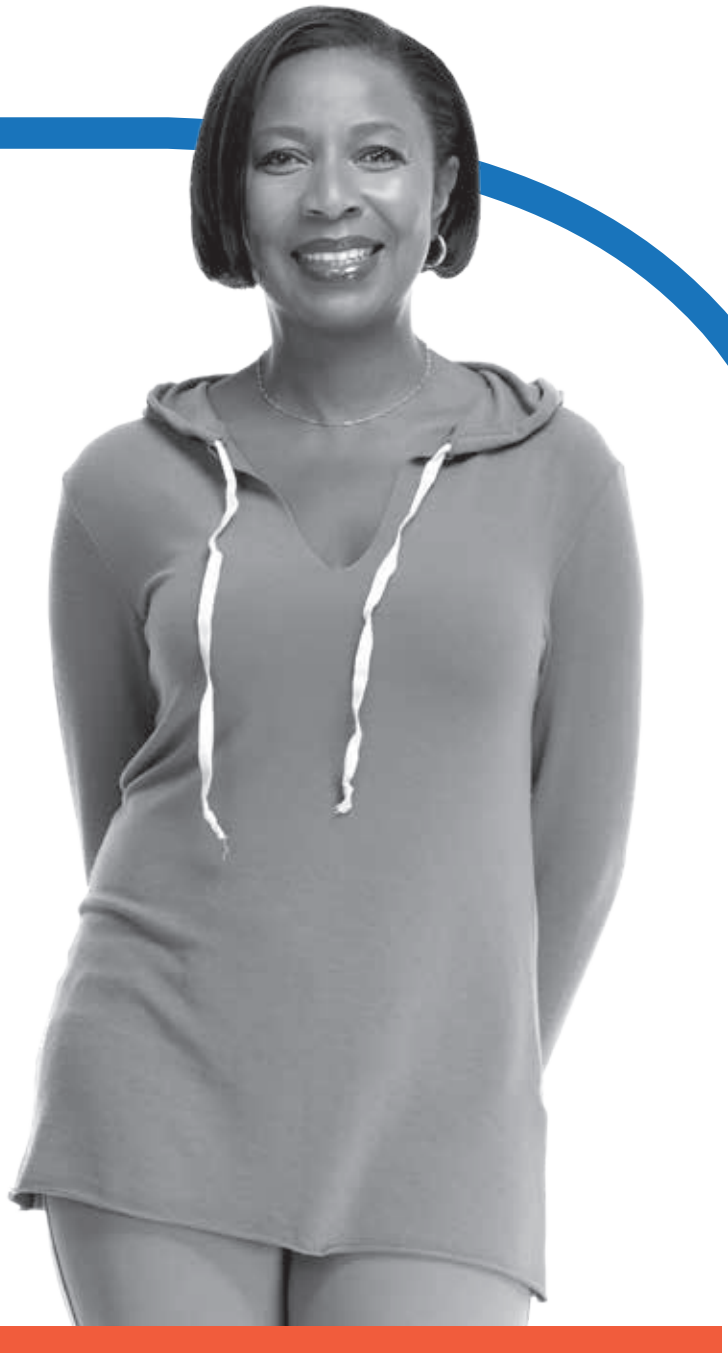
MASSACHUSETTS



2022 PRIOR AUTHORIZATION CRITERIA FOR

Medicare HMO Blue (HMO)
Medicare PPO Blue (PPO)

Definition of Prior Authorization

For certain drugs, your doctor or health care provider will need to contact us before you fill your prescription. The following list of prescription drugs is subject to Prior Authorization.

Y0014_2196_C

ABIRATERONE ACETATE (ZYTIGA)

Products Affected

- abiraterone oral tablet 250 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ABRAXANE

Products Affected

- Abraxane

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist, or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ACTEMRA

Products Affected

- Actemra ACTPen
- Actemra intravenous
- Actemra subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz/Xeljanz XR.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, or a pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADAKVEO

Products Affected

- Adakveo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADBRY

Products Affected

- Adbry

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Atopic dermatitis: A documented diagnosis of moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking Adempas or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on Adempas or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADVAIR

Products Affected

- Advair HFA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For a diagnosis of asthma: Previous treatment/contraindication with Dulera or Symbicort.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AIMOVIG

Products Affected

- Aimovig Autoinjector

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of migraine headache: Documentation that the requested medication is being used for migraine prophylaxis and previous treatment with or contraindication to 2 generic migraine medications including: beta blockers, topiramate, divalproex sodium, non-steroidal anti-inflammatories, and serotonin receptor agonists.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ALGLUCERASE

Products Affected

- Cerezyme intravenous recon soln 400 unit

PA Criteria	Criteria Details
Exclusion Criteria	We do not cover Alglucerase therapy for patients who have Gaucher disease but do not have at least a minimal level of disease severity, because treatment has not been proven to improve health outcomes for patients without signs or symptoms of disease. We do not cover Alglucerase therapy for patients who have Type 2 or Type 3 Gaucher disease, because alglucerase therapy has not been proven to improve the nerve problems associated with these types of Gaucher disease.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALPHA-1 ANTITRYPSIN

Products Affected

- Aralast NP
- Glassia
- Prolastin-C

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Alpha-1 antitrypsin plasma levels less than 80mg/dL (11 umol/L) and FEV1/FVC less than 70%
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ALYMSYS

Products Affected

- Alymsys

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, nephrologist, oncologist, or pulmonologist.
Coverage Duration	3 years
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Mvasi, or Zirabev.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AMBRISENTAN

Products Affected

- ambrisentan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking ambrisentan or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on ambrisentan or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ANABOLIC STEROIDS

Products Affected

- oxandrolone

PA Criteria	Criteria Details
Exclusion Criteria	Weight gain for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with an infectious disease physician, or a pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ARMODAFINIL

Products Affected

- armodafinil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Narcolepsy, Obstructive Sleep Apnea, or Shift Work Sleep Disorder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AUSTEDO

Products Affected

- Austedo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, nephrologist, oncologist, pulmonologist.
Coverage Duration	3 years
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Mvasi, or Zirabev.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AVONEX

Products Affected

- Avonex intramuscular pen injector kit
- Avonex intramuscular syringe kit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, oncologist, allergist, or immunologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BAVENCIO

Products Affected

- Bavencio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, nephrologist, oncologist, or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Exclusion Criteria	Not to be used in patients with severe active central nervous system lupus, and not to be used in combination with other biologics.
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist or nephrologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BESREMI

Products Affected

- Besremi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BEXAROTENE

Products Affected

- bexarotene

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BOSENTAN

Products Affected

- bosentan
- Tracleer oral tablet for suspension

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking bosentan or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on bosentan or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Exclusion Criteria	Botox will not be approved if used for cosmetic reasons.
Required Medical Information	For a diagnosis of migraine headache: episodes of migraine greater than or equal to 15 days per month with duration of greater than or equal to 4 hours per day and previous treatment with or contraindication to 2 migraine prophylactic medications including: beta blockers, topiramate, divalproex sodium, non-steroidal anti-inflammatories, and serotonin receptor agonists.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BRAFTOVI

Products Affected

- Braftovi oral capsule 75 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BRONCHITOL

Products Affected

- Bronchitol

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BYLVAY

Products Affected

- Bylvay

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, hepatologist, nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CALQUENCE

Products Affected

- Calquence
- Calquence (acalabrutinib mal)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CAMZYOS

Products Affected

- Camzyos

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CHORIONIC GONADOTROPINS (HCG)

Products Affected

- chorionic gonadotropin, human intramuscular
- Novarel

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

CIBINQO

Products Affected

- Cibinqo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CIMZIA

Products Affected

- Cimzia
- Cimzia Powder for Reconst
- Cimzia Starter Kit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	All FDA-approved indications are covered per package insert. The following diagnoses require treatment failures and/or contraindications to the following medications. Crohn's disease: failure/contraindication to two of the following: Humira, Skyrizi, or Stelara. Rheumatoid arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz/Xeljanz XR. Psoriatic arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Otezla, Rinvoq, Stelara, Skyrizi, Taltz or Xeljanz/Xeljanz XR. Ankylosing Spondylitis: failure/contraindication to two of the following: Enbrel, Humira, Rinvoq, or Taltz. Plaque Psoriasis: failure/contraindication to two of the following: Enbrel, Humira, Otezla, Skyrizi, Stelara, or Taltz.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CLOMIPHENE

Products Affected

- Clomid
- clomiphene citrate

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for infertility treatment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, hepatologist, nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medical history, medication use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

COSENTYX

Products Affected

- Cosentyx
- Cosentyx (2 Syringes)
- Cosentyx Pen
- Cosentyx Pen (2 Pens)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Ankylosing Spondylitis: failure/contraindication to two of the following: Enbrel, Humira, Rinvoq, or Taltz. Nonradiographic Axial Spondyloarthritis: failure/contraindication to Taltz. Psoriatic Arthritis: failure/contraindication to two of the following for members greater than 18 years of age: Enbrel, Humira, Orencia, Otezla, Rinvoq, Stelara, Skyrizi, Taltz, or Xeljanz/Xeljanz XR. Plaque Psoriasis: failure/contraindication to two of the following for members greater than 18 years of age: Enbrel, Humira, Otezla, Skyrizi, Stelara, or Taltz.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DALFAMPRIDINE

Products Affected

- dalfampridine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DANYELZA

Products Affected

- Danyelza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DARZALEX

Products Affected

- Darzalex
- Darzalex Faspro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DIMETHYL FUMARATE

Products Affected

- dimethyl fumarate oral capsule,delayed release(DR/EC) 120 mg, 120 mg (14)- 240 mg (46), 240 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DOJOLVI

Products Affected

- Dojolvi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DUPIXENT

Products Affected

- Dupixent Pen
- Dupixent Syringe

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Asthma: Documentation that Dupixent is being used as add-on maintenance treatment of patients with moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma. Atopic dermatitis: A documented diagnosis of moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Rhinosinusitis: Documentation that Dupixent is being used as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist, immunologist, dermatologist, ENT specialist, or pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DYSPORT

Products Affected

- Dysport

PA Criteria	Criteria Details
Exclusion Criteria	Dysport will not be approved if used for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EGRIFTA

Products Affected

- Egrifta SV

PA Criteria	Criteria Details
Exclusion Criteria	Weight loss management.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EMGALITY

Products Affected

- Emgality Pen
- Emgality Syringe subcutaneous syringe 120 mg/mL, 300 mg/3 mL (100 mg/mL x 3)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of migraine headache: Documentation that the requested medication is being used for migraine prophylaxis and previous treatment with or contraindication to 2 generic migraine medications including: beta blockers, topiramate, divalproex sodium, non-steroidal anti-inflammatories, and serotonin receptor agonists.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EMPAVELI

Products Affected

- Empaveli

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ENBREL

Products Affected

- Enbrel Mini
- Enbrel subcutaneous recon soln
- Enbrel subcutaneous solution
- Enbrel subcutaneous syringe
- Enbrel SureClick

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ENHERTU

Products Affected

- Enhertu

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ENJAYMO

Products Affected

- Enjaymo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ENSPRYNG

Products Affected

- Enspryng

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ENTYVIO

Products Affected

- Entyvio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Adult Crohn's disease: failure/contraindication to two of the following: Humira, Skyrizi, or Stelara. Adult Ulcerative Colitis: failure/contraindication to two of the following: Humira, Rinvoq, Stelara or Xeljanz/Xeljanz XR.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	1 year of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ERBITUX

Products Affected

- Erbitux

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERLOTINIB

Products Affected

- erlotinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or nephrologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERYTHROPOIETIN

Products Affected

- Retacrit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Current hemoglobin level within the previous 30 days less than or equal to 10g/dL. Anemic surgical patients must meet the following criteria: surgery must be elective, non-cardiac, and non-vascular, target hemoglobin level between 10 and 13 g/dL, and not willing to donate blood.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an End-Stage Renal Disease (ESRD)-related condition.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anemia due to ribavirin therapy in the treatment of Hepatitis C and Myelodysplastic Syndromes.

ESBRIET

Products Affected

- Esbriet
- pirfenidone oral tablet 267 mg, 801 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Idiopathic Pulmonary Fibrosis.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EVENITY

Products Affected

- Evenity

PA Criteria	Criteria Details
Exclusion Criteria	Duration of use for Evenity is limited to 12 monthly doses.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorizations will be approved for 12 months of therapy.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EVEROLIMUS (AFINITOR)

Products Affected

- everolimus (antineoplastic)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist, neurologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EVKEEZA

Products Affected

- Evkeeza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	Homozygous familial hypercholesterolemia: 12 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	The requested medication must be used as an adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EVRYSDI

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EXKIVITY

Products Affected

- Exkivity

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FARYDAK

Products Affected

- Farydak oral capsule 10 mg, 15 mg, 20 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that Fasenra is being used as add-on maintenance treatment of patients with severe asthma with an eosinophilic phenotype.
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with an allergist, immunologist, or pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FENTANYL, ORAL TRANSMUCOSAL

Products Affected

- fentanyl citrate buccal lozenge on a handle

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	We cover Fentanyl, oral/transmucosal when the patient is already receiving and is tolerant to other opioids. Opioid tolerance defined as taking one or more of the following medications at or above the listed doses for at least one week: oral morphine 60mg/day, transdermal fentanyl 25mcg/hr, oral hydromorphone 8mg/day or any equianalgesic dose of another opioid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FULPHILA

Products Affected

- Fulphila

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

GALAFOLD

Products Affected

- Galafold

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Fabry disease: a confirmed diagnosis of Fabry disease and an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GAMIFANT

Products Affected

- Gamifant

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GATTEX

Products Affected

- Gattex 30-Vial
- Gattex One-Vial

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GAZYVA

Products Affected

- Gazyva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GEMTESA

Products Affected

- Gemtesa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, Myrbetriq.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GILENYA

Products Affected

- ztallimod
- fingolimod oral capsule 0.5mg
- Gilenya oral capsule 0.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GIVLAARI

Products Affected

- Givlaari

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GLATIRAMER

Products Affected

- glatiramer subcutaneous syringe 20 mg/mL, 40 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GLATOPA

Products Affected

- Glatopa subcutaneous syringe 20 mg/mL, 40 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GROWTH HORMONE

Products Affected

- Omnitrope
- Serostim subcutaneous recon soln 4 mg, 5 mg, 6 mg
- Zorbtive

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GROWTH HORMONE (INSULIN LIKE GROWTH FACTOR)

Products Affected

- Increlex

PA Criteria	Criteria Details
Exclusion Criteria	We do not cover Insulin like Growth Factor for secondary forms of IGF-1 deficiency to include (but not limited to): GH deficiency, malnutrition, hypothyroidism, or for chronic treatment with pharmacologic doses of anti-inflammatory steroids.
Required Medical Information	Height standard deviation score less than or equal to -3 for age and sex, basal IGF-1 standard deviation score less than or equal to -3 for age and sex, and normal or elevated growth hormone (defined as stimulated serum GH peak level of greater than 10 ng/ml or basal (unstimulated) serum GH level greater than 5ng/ml).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HALAVEN

Products Affected

- Halaven

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	3 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HERCEPTIN

Products Affected

- Herceptin intravenous recon soln 150 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, or oncologist.
Coverage Duration	3 years
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Herzuma, Kanjinti, Ogivri, Ontruzant, or Trazimera.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HERCEPTIN HYLECTA

Products Affected

- Herceptin Hylecta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HERZUMA

Products Affected

- Herzuma

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HETLIOZ

Products Affected

- Hetlioz
- Hetlioz LQ

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - BARBITURATES

Products Affected

- Ascomp with Codeine
- Butalbital Compound W/Codeine
- butalbital-acetaminop-caf-cod
- butalbital-acetaminophen
- butalbital-acetaminophen-caff oral tablet
- butalbital-aspirin-caffeine
- codeine-butalbital-ASA-caff
- Tencon
- Vtol LQ
- Zebutal

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

Products Affected

- diphenhydramine HCl oral elixir
- hydroxyzine HCl oral solution 10 mg/5 mL
- hydroxyzine HCl oral tablet
- hydroxyzine pamoate
- promethazine oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For promethazine tablets/syrup, authorize use without a previous drug trial for all FDA-approved indications other than emesis, including cancer/chemo-related emesis. For hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules), authorize use without a previous drug trial for all FDA-approved indications other than anxiety. For the treatment of non-cancer/chemo related emesis, approve promethazine hydrochloride tablets or syrup if the patient has previous treatment/contraindication with at least one other prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, palonosetron, aprepitant). Approve hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules) if the patient has previous treatment/contraindication with at least two other FDA-approved products for the management of anxiety. Approve hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules) for pruritis due to allergic and dermatological conditions. Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - PHENOBARBITAL/PENTOBARBITAL

Products Affected

- phenobarbital

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - SKELETAL MUSCLE RELAXANTS

Products Affected

- carisoprodol
- carisoprodol-aspirin-codeine
- chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg
- cyclobenzaprine oral tablet
- metaxalone
- methocarbamol injection
- methocarbamol oral tablet 500 mg, 750 mg
- orphenadrine citrate oral
- orphenadrine-ASA-caffeine oral tablet 25-385-30 mg
- Orphengesic Forte
- Vanadom

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - TERTIARY TRICYCLIC ANTIDEPRESSANTS

Products Affected

- amitriptyline
- clomipramine
- doxepin oral capsule
- doxepin oral concentrate
- imipramine HCl
- imipramine pamoate
- perphenazine-amitriptyline
- trimipramine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HUMIRA

Products Affected

- Humira Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira subcutaneous syringe kit 40 mg/0.8 mL
- Humira(CF) Pedi Crohns Starter subcutaneous syringe kit 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Pediatric UC
- Humira(CF) Pen Psor-Uv-Adol HS
- Humira(CF) Pen subcutaneous pen injector kit 40 mg/0.4 mL, 80 mg/0.8 mL
- Humira(CF) subcutaneous syringe kit 10 mg/0.1 mL, 20 mg/0.2 mL, 40 mg/0.4 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, dermatologist, or ophthalmologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ILARIS

Products Affected

- Ilaris (PF)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Systemic juvenile idiopathic arthritis: failure/contraindication to two of the following: Enbrel, Humira, or Orencia.
Age Restrictions	N/A
Prescriber Restrictions	For Systemic Juvenile Idiopathic Arthritis: prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 Year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IMATINIB

Products Affected

- imatinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, hematologist, oncologist, allergist or immunologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IMBRUVICA

Products Affected

- Imbruvica oral capsule 140 mg, 70 mg
- Imbruvica oral suspension
- Imbruvica oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, oncologist, or transplant specialist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IMFINZI

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist, pulmonologist, or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INBRIJA

Products Affected

- Inbrija inhalation capsule, w/inhalation device

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Parkinson's disease and Inbrija must be used for the intermittent treatment of off episodes in patients treated with carbidopa/levodopa.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLECTRA

Products Affected

- Inflectra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis: taken with methotrexate and failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz. Psoriatic Arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Otezla, Rinvoq, Skyrizi, Stelara, Taltz, or Xeljanz. Adult Crohn's disease: failure/contraindication to two of the following: Humira, Skyrizi, or Stelara. Adult Ulcerative Colitis: failure/contraindication to two of the following: Humira, Rinvoq, Stelara or Xeljanz/Xeljanz XR. Ankylosing Spondylitis: failure/contraindication to two of the following: Enbrel, Humira, Rinvoq, or Taltz. Plaque Psoriasis: failure/contraindication to two of the following: Enbrel, Humira, Otezla, Skyrizi, Stelara, or Taltz.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 Year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INTERFERONS (INTERFERON ALPHA)

Products Affected

- Intron A injection recon soln 10 million unit (1 mL), 50 million unit (1 mL)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INTERFERONS (INTERFERON GAMMA)

Products Affected

- Actimmune

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ISTURISA

Products Affected

- Isturisa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IVIG

Products Affected

- Gammagard Liquid
- Gammagard S-D (IgA < 1 mcg/mL)
- Gamunex-C injection solution 1 gram/10 mL (10 %)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in patients home.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IXEMPRA

Products Affected

- Ixempra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, oncologist, or transplant specialist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

JEVTANA

Products Affected

- Jevtana

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

JUXTAPID

Products Affected

- Juxtapid oral capsule 10 mg, 20 mg, 30 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of Homozygous Familial Hypercholesterolemia. Juxtapid must also be used as an adjunct to lipid lowering therapies unless the patient has a documented contraindication to lipid-lowering therapies.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KADCYLA

Products Affected

- Kadcyla

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KALYDECO

Products Affected

- Kalydeco oral granules in packet
- Kalydeco oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of one mutation in the CFTR gene that is responsive to Kalydeco as confirmed by an FDA-cleared cystic fibrosis mutation test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KANJINTI

Products Affected

- Kanjinti

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KESIMPTA

Products Affected

- Kesimpta Pen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KEVZARA

Products Affected

- Kevzara

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz/Xeljanz XR.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, gastroenterologist, gynecologist, hematologist, hepatologist, oncologist, pulmonologist, or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KIMMTRAK

Products Affected

- Kimmtrak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz/Xeljanz XR.
Age Restrictions	N/A
Prescriber Restrictions	For Rheumatoid Arthritis: prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KISQALI

Products Affected

- Kisqali
- Kisqali Femara Co-Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	Previous treatment with, or a contraindication to, Ibrance.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KOSELUGO

Products Affected

- Koselugo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KYPROLIS

Products Affected

- Kyprolis

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LENVIMA

Products Affected

- Lenvima

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, hepatologist, nephrologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LEUKINE

Products Affected

- Leukine injection recon soln

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

LIBTAYO

Products Affected

- Libtayo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LIDOCAINE

Products Affected

- lidocaine topical adhesive patch,medicated 5 %

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Diabetic neuropathic pain.

LIVMARLI

Products Affected

- Livmarli

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LIVTENCITY

Products Affected

- Livtencity

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LONG ACTING OPIOIDS

Products Affected

- buprenorphine
- hydrocodone bitartrate
- hydromorphone oral tablet extended release 24 hr
- Methadone Intensol
- methadone oral concentrate
- methadone oral solution
- methadone oral tablet
- Methadose oral concentrate
- morphine oral capsule, ER multiphase 24 hr
- morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg
- morphine oral tablet extended release
- oxymorphone oral tablet extended release 12 hr
- tramadol oral tablet extended release 24 hr
- tramadol oral tablet, ER multiphase 24 hr
- Xtampza ER

PA Criteria	Criteria Details
Exclusion Criteria	Acute (i.e., non-chronic) pain
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment (with no cancer diagnosis, not in long term care facility and not in hospice), approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (e.g., addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescribing physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off-Label Uses	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LUMOXITI

Products Affected

- Lumoxiti

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	N/A
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LUPKYNIS

Products Affected

- Lupkynis

PA Criteria	Criteria Details
Exclusion Criteria	Not to be used in combination with cyclophosphamide.
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gynecologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MAVENCLAD

Products Affected

- Mavenclad (10 tablet pack)
- Mavenclad (4 tablet pack)
- Mavenclad (5 tablet pack)
- Mavenclad (6 tablet pack)
- Mavenclad (7 tablet pack)
- Mavenclad (8 tablet pack)
- Mavenclad (9 tablet pack)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MAVYRET

Products Affected

- Mavyret oral pellets in packet
- Mavyret oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotypes 1 and 4, patients must have a trial with Epclusa or Harvoni unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines. For genotypes 2 and 3, patients must have a trial with Epclusa unless Epclusa is not specifically listed as an alternative therapy for a specific patient population in the guidelines. For genotypes 5 and 6, patients must have a trial with Epclusa or Harvoni, unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MAYZENT

Products Affected

- Mayzent oral tablet 0.25 mg, 1 mg, 2 mg
- Mayzent Starter(for 1mg maint)
- Mayzent Starter(for 2mg maint)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MEGESTROL SUSPENSION/TABLETS

Products Affected

- megestrol oral suspension 400 mg/10 mL (10 mL), 400 mg/10 mL (40 mg/mL), 625 mg/5 mL (125 mg/mL)
- megestrol oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight gain for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, endocrinologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEPERIDINE

Products Affected

- meperidine (PF) injection solution 100 mg/mL, 25 mg/mL, 50 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, require prior authorization.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

METHAMPHETAMINE (DESOXYN)

Products Affected

- methamphetamine

PA Criteria	Criteria Details
Exclusion Criteria	Weight loss.
Required Medical Information	Diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MODAFINIL

Products Affected

- modafinil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Narcolepsy, Obstructive Sleep Apnea, or Shift Work Sleep Disorder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MONJUVI

Products Affected

- Monjuvi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MVASI

Products Affected

- Mvasi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, nephrologist, oncologist, or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	1 year
Other Criteria	Chronic hypoparathyroidism - Before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEULASTA

Products Affected

- Neulasta
- Neulasta Onpro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Fulphila or Udenyca.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Granix, or Zarxio.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEXAVAR

Products Affected

- sorafenib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, hepatologist, nephrologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEXLETOL

Products Affected

- Nexletol

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NEXLIZET

Products Affected

- Nexlizet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NILUTAMIDE

Products Affected

- nilutamide

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NIVESTYM

Products Affected

- Nivestym

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Granix, or Zarxio.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NOURIANZ

Products Affected

- Nourianz

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Parkinson's disease and must be used as adjunctive treatment to levodopa/carbidopa in adult patients experiencing off episodes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that Nucala is being used for hypereosinophilic syndrome or as add-on maintenance treatment of patients with severe asthma with an eosinophilic phenotype, eosinophilic granulomatosis with polyangiitis, or chronic rhinosinusitis with nasal polyps (CRSwNP).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with an allergist, immunologist, pulmonologist, rheumatologist, hematologist or otolaryngologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Exclusion Criteria	Use in the management of neuropathic pain. Use in the management of heroin detoxification.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NURTEC

Products Affected

- Nurtec ODT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of migraine headache: Previous treatment with or contraindication to 2 generic migraine medications including: beta blockers, topiramate, divalproex sodium, non-steroidal anti-inflammatories, and serotonin receptor agonists.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NYVEPRIA

Products Affected

- Nyvepria

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Fulphila, Udenyca, or Ziextenzo.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OCREVUS

Products Affected

- Ocrevus

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OGIVRI

Products Affected

- Ogivri

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ONGENTYS

Products Affected

- Ongentys

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Parkinson's disease and must be used as adjunctive treatment to levodopa/carbidopa in adult patients experiencing off episodes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONIVYDE

Products Affected

- Onivyde

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ONPATTRO

Products Affected

- Onpattro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONTRUZANT

Products Affected

- Ontruzant

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OPDIVO

Products Affected

- Opdivo intravenous solution 100 mg/10 mL, 120 mg/12 mL, 240 mg/24 mL, 40 mg/4 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OPDUALAG

Products Affected

- Opdualag

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking Opsumit or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on Opsumit or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OPZELURA

Products Affected

- Opzelura

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Atopic dermatitis: A documented diagnosis of mild-to-moderate atopic dermatitis in non-immunocompromised members whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORENCIA

Products Affected

- Orencia (with maltose)
- Orencia ClickJect
- Orencia subcutaneous syringe 125 mg/mL, 50 mg/0.4 mL, 87.5 mg/0.7 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORENITRAM

Products Affected

- Orenitram

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking Orenitram or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on Orenitram or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORKAMBI

Products Affected

- Orkambi oral granules in packet 100-125 mg, 150-188 mg, 75-94 mg
- Orkambi oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Kalydeco. Patients who are heterozygous for the F508del mutation.
Required Medical Information	Documentation the patient is homozygous for the F508del mutation in the CFTR gene as confirmed by an FDA-cleared cystic fibrosis mutation test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORLADEYO

Products Affected

- Orladeyo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OTEZLA

Products Affected

- Otezla
- Otezla Starter oral tablets,dose pack 10 mg (4)-20 mg (4)-30 mg (47)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OXBRYTA

Products Affected

- Oxbryta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an ophthalmologist or optometrist.
Coverage Duration	8 weeks
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OXLUMO

Products Affected

- Oxlumo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PADCEV

Products Affected

- Padcev

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist, or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PANRETIN

Products Affected

- Panretin

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, infectious disease physician or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, hepatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PERJETA

Products Affected

- Perjeta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PHESGO

Products Affected

- Phesgo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PHOSPHODIESTERASE INHIBITORS (PULMONARY HYPERTENSION)

Products Affected

- Alyq
- sildenafil (Pulmonary Arterial Hypertension)
- tadalafil (pulmonary arterial hypertension) oral tablet 20 mg
- Tadliq

PA Criteria	Criteria Details
Exclusion Criteria	We do not cover phosphodiesterase inhibitors for the treatment of erectile dysfunction.
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking an agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on an agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PIQRAY

Products Affected

- Piqray

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PLEGRIDY

Products Affected

- Plegridy intramuscular
- Plegridy subcutaneous pen injector 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL
- Plegridy subcutaneous syringe

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

POLIVY

Products Affected

- Polivy

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PONVORY

Products Affected

- Ponvory
- Ponvory 14-Day Starter Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

POTELIGEO

Products Affected

- Poteligeo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PRALUENT

Products Affected

- Praluent Pen subcutaneous pen injector
  150 mg/mL, 75 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medical history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	For Primary Hyperlipidemia including pts with HeFH without ASCVD - approve if pt meets all of the following: A. Pt has been diagnosed with Primary Hyperlipidemia or HeFH, AND B. Pt tried TWO high intensity statins (i.e. atorvastatin greater than or equal to 40 mg daily and rosuvastatin greater than or equal to 20 mg daily) AND LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation, AND C. If able to tolerate statins, the pt continues to receive the maximum tolerated dose of a statin while receiving Praluent therapy. Hyperlipidemia in pts with Clinical Atherosclerotic Cardiovascular Disease (ASCVD) with or without HeFH- approve if pt meets all of the following: A. Pt has an LDL-C greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 therapy), AND B. Pt has one of the following conditions: prior MI, history of ACS, diagnosis of angina, history of stroke or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND C. Pt tried TWO high intensity statins (i.e. atorvastatin greater than or equal to 40 mg daily and rosuvastatin greater than or equal to 20 mg daily)

PA Criteria	Criteria Details
	AND LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation, AND D. If able to tolerate statins, the pt continues to receive the maximum tolerated dose of a statin while receiving Praluent therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The patient has a documented diagnosis of osteoporosis, treatment of androgen deprivation-induced bone loss in men with prostate cancer, or treatment of aromatase inhibitor-induced bone loss in women with breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For a documented diagnosis of osteoporosis there must be evidence of a paid claim or physician documented use of one or more oral bisphosphonates (e.g. alendronate) or inability to swallow or inability to remain in an upright position during post oral bisphosphonate administration.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PYRIMETHAMINE

Products Affected

- pyrimethamine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PYRUKYND

Products Affected

- Pyrukynd oral tablet 20 mg, 5 mg, 50 mg
- Pyrukynd oral tablets,dose pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REBIF

Products Affected

- Rebif (with albumin)
- Rebif Rebidose subcutaneous pen injector 22 mcg/0.5 mL, 44 mcg/0.5 mL, 8.8mcg/0.2mL-22 mcg/0.5mL (6)
- Rebif Titration Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: dimethyl fumarate, glatiramer, or glatopa.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

REBLOZYL

Products Affected

- Reblozyl

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RECORLEV

Products Affected

- Recorlev

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RELEUKO

Products Affected

- Releuko

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Granix, or Zarxio.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RETINOIC ACID DERIVATIVES

Products Affected

- adapalene topical cream
- adapalene topical gel
- adapalene topical gel with pump
- adapalene topical solution
- adapalene topical swab
- adapalene-benzoyl peroxide
- Avita topical cream
- clindamycin-tretinoin
- tazarotene topical cream
- tazarotene topical foam
- tazarotene topical gel
- Tazorac topical cream 0.05 %
- Tazorac topical gel
- tretinoin microspheres
- tretinoin topical

PA Criteria	Criteria Details
Exclusion Criteria	Coverage for all ages is restricted to non-cosmetic purposes only.
Required Medical Information	Adapalene: Documented diagnosis of acne vulgaris. Tazarotene: Documented diagnosis of acne or psoriasis. Tretinoin: Documented diagnosis of acne or actinic keratosis.
Age Restrictions	Prior authorization is only required for patients over 29 years of age in order to evaluate for non-cosmetic uses.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REVLIMID

Products Affected

- lenalidomide
- Revlimid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REZUROCK

Products Affected

- Rezurock

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RIABNI

Products Affected

- Riabni

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RINVOQ

Products Affected

- Rinvoq oral tablet extended release 24 hr
  15 mg, 30 mg, 45 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis: taken with methotrexate and previous treatment with, or a contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz/Xeljanz XR. For all other biosimilar indications: Previous treatment with, or a contraindication to, one of the following: Ruxience, or Truxima.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consulation with, a dermatologist, hematologist, oncologist, or rheumatologist.
Coverage Duration	Oncology indications: 3 years. Non-oncology indications: 1 year.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RITUXAN HYCELA

Products Affected

- Rituxan Hycela

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gynecologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RUXIENCE

Products Affected

- Ruxience

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RYBREVANT

Products Affected

- Rybrevant

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RYLAZE

Products Affected

- Rylaze

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SARCLISA

Products Affected

- Sarclisa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SCEMBLIX

Products Affected

- Scemblix

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SIMPONI

Products Affected

- Simponi ARIA
- Simponi subcutaneous pen injector 100 mg/mL, 50 mg/0.5 mL
- Simponi subcutaneous syringe 100 mg/mL, 50 mg/0.5 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis: taken with methotrexate and failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz/Xeljanz XR. Psoriatic arthritis: taken alone, or in combination with methotrexate and failure/contraindication to two of the following: Enbrel, Humira, Orencia, Otezla, Rinvoq, Stelara, Skyrizi, Taltz, or Xeljanz/Xeljanz XR. Ankylosing Spondylitis: failure/contraindication to two of the following: Enbrel, Humira, Rinvoq, or Taltz. Ulcerative colitis: failure/contraindication to two of the following: Humira, Rinvoq, Stelara, or Xeljanz/Xeljanz XR.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SKYRIZI

Products Affected

- Skyrizi intravenous
- Skyrizi subcutaneous pen injector
- Skyrizi subcutaneous syringe 150 mg/mL
- Skyrizi subcutaneous syringe kit
- Skyrizi subcutaneous wearable injector

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOLIQUA

Products Affected

- Soliqua 100/33

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Lantus, Toujeo, Bydureon, Byetta, or Trulicity.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	Genotype 1 and 4: 18 years of age and older, Genotype 2 and 3: 3 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotypes 1 and 4, patients must have a trial with Epclusa or Harvoni unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines. For genotypes 2 and 3, patients must have a trial with Epclusa unless Epclusa is not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

STELARA

Products Affected

- Stelara intravenous
- Stelara subcutaneous solution
- Stelara subcutaneous syringe 45 mg/0.5 mL, 90 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, hepatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SUNITINIB

Products Affected

- sunitinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, nephrologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYMDEKO

Products Affected

- Symdeko oral tablets, sequential 100-150 mg (d)/ 150 mg (n), 50-75 mg (d)/ 75 mg (n)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that the patient has cystic fibrosis and is homozygous for the F508del mutation as confirmed by an FDA-cleared cystic fibrosis mutation test OR has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Symdeko based on in vitro data and/or clinical evidence.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TADALAFIL (CIALIS)

Products Affected

- tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	We do not cover tadalafil for the treatment of erectile dysfunction.
Required Medical Information	The patient must have a documented diagnosis of Benign Prostatic Hyperplasia (BPH).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, endocrinologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAKHZYRO

Products Affected

- Takhzyro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TALTZ

Products Affected

- Taltz Autoinjector
- Taltz Autoinjector (2 Pack)
- Taltz Autoinjector (3 Pack)
- Taltz Syringe

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TARPEYO

Products Affected

- Tarpeyo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAVNEOS

Products Affected

- Tavneos

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist, pulmonologist, or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEPEZZA

Products Affected

- Tepezza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TERIPARATIDE

Products Affected

- teriparatide

PA Criteria	Criteria Details
Exclusion Criteria	Previous use of Tymlos, Forteo and/or teriparatide for a combined total no greater than 2 years duration during a patient's lifetime.
Required Medical Information	Documentation teriparatide is being used in one the following patient populations at high risk for fracture (defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapies): Postmenopausal women with osteoporosis, to increase bone mass in men with primary or hypogonadal osteoporosis, men and women with glucocorticoid-induced osteoporosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorizations will be approved for 2 years of therapy over a patient's lifetime.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TETRABENAZINE

Products Affected

- tetrabenazine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEZSPIRE

Products Affected

- Tezspire

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with an allergist, immunologist, or pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TIVDAK

Products Affected

- Tivdak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOPICAL IMMUNOMODULATORS

Products Affected

- pimecrolimus
- tacrolimus topical

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented treatment failure or contraindication with a prescription topical corticosteroid within the previous 90 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOPIRAMATE/ZONISAMIDE

Products Affected

- Eprontia
- topiramate oral capsule, sprinkle
- topiramate oral tablet
- Trokendi XR
- Zonisade
- zonisamide

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight loss or smoking cessation.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRAZIMERA

Products Affected

- Trazimera

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRODELVY

Products Affected

- Trodelvy

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRUSELTIQ

Products Affected

- Truseltiq oral capsule 100 mg/day (100 mg x 1), 125 mg/day(100 mg x1-25mg x1), 50 mg/day (25 mg x 2), 75 mg/day (25 mg x 3)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRUXIMA

Products Affected

- Truxima

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, rheumatologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TYKERB

Products Affected

- lapatinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Exclusion Criteria	Tysabri will not be approved when used in combination with other immune modulating medications for the treatment of Multiple Sclerosis. Tysabri will not be approved when used in combination with immunosuppressants or TNF-a inhibitors for the treatment of Crohn's Disease.
Required Medical Information	Multiple Sclerosis: The patient must have a documented diagnosis of a relapsing form of Multiple Sclerosis. Crohn's Disease: The patient must have a documented diagnosis of Crohn's Disease and failure/contraindication to two of the following: Humira, Skyrizi, or Stelara.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or neurologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

UBRELVY

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of migraine headache: Previous treatment with or contraindication to 2 generic migraine medications including: beta blockers, topiramate, divalproex sodium, non-steroidal anti-inflammatories, and serotonin receptor agonists.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

UDENYCA

Products Affected

- Udenyca

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

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking Uptravi or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on Uptravi or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VASCEPA

Products Affected

- icosapent ethyl
- Vascepa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VENCLEXTA

Products Affected

- Venclexta oral tablet 10 mg, 100 mg, 50 mg
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VIEKIRA

Products Affected

- Viekira Pak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotype 1, patients must have a trial with Epclusa or Harvoni, unless Epclusa or Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VIJOICE

Products Affected

- Vijoice

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VORICONAZOLE

Products Affected

- voriconazole intravenous

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VOXZOGO

Products Affected

- Voxzogo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VTAMA

Products Affected

- Vtama

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VYNDAMAX

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VYNDAQEL

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XELJANZ

Products Affected

- Xeljanz oral solution
- Xeljanz oral tablet
- Xeljanz XR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	All FDA-approved indications are covered per package insert. The following diagnoses require treatment failures and/or contraindications to the following medications. Rheumatoid Arthritis: previous failure/contraindication to methotrexate.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XEOMIN

Products Affected

- Xeomin

PA Criteria	Criteria Details
Exclusion Criteria	Xeomin will not be approved if used for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Allergic mediated moderate to severe asthma: Asthma symptoms not adequately controlled by continuous therapy of inhaled steroids or oral steroids, recent IgE levels within the range of 30 to 1,300 IU/mL for children 6 to less than 12 years of age or IgE level within the range of 30 to 700 IU/mL for 12 years of age and older (recent defined as the previous 6 months), positive skin test or in vitro testing for one or more perennial aeroallergen. Chronic idiopathic urticaria: Symptoms remain despite H1 antihistamine treatment.
Age Restrictions	Allergic mediated moderate to severe asthma: 6 years of age and older. Chronic idiopathic urticaria: 12 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist, allergist, dermatologist, immunologist, or otolaryngologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XPOVIO

Products Affected

- Xpovio oral tablet 100 mg/week (50 mg x 2), 40 mg/week (40 mg x 1), 40mg twice week (40 mg x 2), 60 mg/week (60 mg x 1), 60mg twice week (120 mg/week), 80 mg/week (40 mg x 2), 80mg twice week (160 mg/week)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XTANDI

Products Affected

- Xtandi oral capsule
- Xtandi oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a sleep specialist or neurologist.
Coverage Duration	1 year
Other Criteria	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate or dextroamphetamine), modafinil, or armodafinil.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

YERVOY

Products Affected

- Yervoy

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, gastroenterologist, hepatologist, nephrologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gynecologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotypes 1 and 4, patients must have a trial with Epclusa or Harvoni unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZEPOSIA

Products Affected

- Zeposia
- Zeposia Starter Kit
- Zeposia Starter Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Multiple sclerosis: previous treatment with, or a contraindication to, one of the following medications is required: dimethyl fumarate, glatiramer, or glatopa. Ulcerative colitis: failure/contraindication to two of the following: Humira, Rinvoq, Stelara, or Xeljanz/Xeljanz XR.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist, MS specialist, or gastroenterologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZIEXTENZO

Products Affected

- Ziextenzo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Previous treatment with, or a contraindication to, one of the following medications: Fulphila or Udenyca.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZINPLAVA

Products Affected

- Zinplava

PA Criteria	Criteria Details
Exclusion Criteria	Zinplava is not indicated for the treatment of Clostridium difficile infection (CDI).
Required Medical Information	Zinplava must be prescribed for patients who are receiving an antibacterial drug treatment regimen for CDI and must be at high risk for CDI recurrence.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or infectious disease physician.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZIRABEV

Products Affected

- Zirabev

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, nephrologist, oncologist, or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZOKINVY

Products Affected

- Zokinvy

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZTALMY

Products Affected

- Ztalmy

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

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PART B VERSUS PART D

Products Affected

- acetylcysteine
- acyclovir sodium intravenous solution
- albuterol sulfate inhalation solution for nebulization
- AmBisome
- amiodarone intravenous
- amphotericin B
- amphotericin B liposome
- aprepitant
- arformoterol
- Arzerra
- Astagraf XL
- azathioprine
- azathioprine sodium
- baclofen intrathecal
- Blenrep
- bleomycin
- Blincyto intravenous kit
- Brovana
- budesonide inhalation
- caspofungin
- cidofovir
- cladribine
- Clinimix 5%/D15W Sulfite Free
- Clinimix 4.25%/D10W Sulf Free
- Clinimix 4.25%/D5W Sulfit Free
- Clinimix 5%-D20W(sulfite-free)
- Clinimix 6%-D5W (sulfite-free)
- Clinimix 8%-D10W(sulfite-free)
- Clinimix 8%-D14W(sulfite-free)
- Clinimix E 2.75%/D5W Sulf Free
- Clinimix E 4.25%/D10W Sul Free
- Clinimix E 4.25%/D5W Sulf Free
- Clinimix E 5%/D15W Sulfit Free
- Clinimix E 5%/D20W Sulfit Free
- Clinimix E 8%-D10W sulfitefree
- Clinimix E 8%-D14W sulfitefree
- Clinisol SF 15 %
- Clinolipid
- cromolyn inhalation
- cyclophosphamide oral capsule
- cyclosporine intravenous
- cyclosporine modified
- cyclosporine oral capsule
- Cyramza
- cytarabine
- cytarabine (PF)
- dobutamine in D5W intravenous parenteral solution 1,000 mg/250 mL (4,000 mcg/mL), 250 mg/250 mL (1 mg/mL), 500 mg/250 mL (2,000 mcg/mL)
- dobutamine intravenous solution 250 mg/20 mL (12.5 mg/mL)
- dopamine in 5 % dextrose
- dopamine intravenous solution 200 mg/5 mL (40 mg/mL), 400 mg/10 mL (40 mg/mL)
- dronabinol
- Elzonris
- Emend oral suspension for reconstitution
- Empliciti
- Engerix-B (PF)
- Engerix-B Pediatric (PF)
- Envarsus XR
- epoprostenol
- epoprostenol (glycine)
- everolimus (immunosuppressive)
- floxuridine
- fluorouracil intravenous
- formoterol fumarate
- foscarnet
- Gamunex-C injection solution 10 gram/100 mL (10 %), 2.5 gram/25 mL (10 %), 20 gram/200 mL (10 %), 40 gram/400 mL (10 %), 5 gram/50 mL (10 %)
- ganciclovir sodium
- Gengraf
- granisetron HCl oral
- Intralipid intravenous emulsion 20 %
- Intralipid intravenous emulsion 30 %
- ipratropium bromide inhalation
- ipratropium-albuterol
- levalbuterol HCl
- melphalan
- methotrexate sodium
- methotrexate sodium (PF)

- methylprednisolone oral tablet
- Millipred oral tablet
- milrinone
- milrinone in 5 % dextrose
- morphine (PF) intravenous patient control.analgesia soln 30 mg/30 mL (1 mg/mL)
- mycophenolate mofetil
- mycophenolate mofetil (HCl)
- mycophenolate sodium
- nitroglycerin in 5 % dextrose intravenous solution 100 mg/250 mL (400 mcg/mL), 25 mg/250 mL (100 mcg/mL), 50 mg/250 mL (200 mcg/mL)
- nitroglycerin intravenous
- Nulibry
- Nulojix
- ondansetron
- ondansetron HCl oral solution
- ondansetron HCl oral tablet 4 mg, 8 mg
- pentamidine inhalation
- Plenamine
- Portrazza
- prednisolone sodium phosphate oral tablet,disintegrating
- Prehevbrio (PF)
- Premasol 10 %
- Prograf intravenous
- Prograf oral granules in packet
- Prosol 20 %
- Pulmozyme
- Recombivax HB (PF)
- Simulect
- sirolimus
- SMOFlipid
- sodium nitroprusside
- Syndros
- tacrolimus oral
- tobramycin in 0.225 % NaCl
- tobramycin inhalation
- Travasol 10 %
- treprostinil sodium
- trimethobenzamide oral
- TrophAmine 10 %
- Tyvaso
- Tyvaso Institutional Start Kit
- Tyvaso Refill Kit
- Tyvaso Starter Kit
- Uplizna
- Varubi
- Vectibix
- Veletri
- Ventavis
- vinblastine
- Vincasar PFS
- vincristine
- Vyxeos
- Xatmep
- Yupelri
- Zepzelca
- Zortress oral tablet 1 mg

Details

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

Index

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Medicare Advantage Appeals and Grievance Manager.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Medicare Advantage Appeals and Grievance Manager by mail at P.O. Box 55007, Boston, MA 02205; phone at **1-800-200-4255** (TTY: **711**) from April 1 through September 30, 8:00 a.m. to 8:00 p.m., Monday through Friday, or October 1 through March 31, 8:00 a.m. to 8:00 p.m., seven days a week; fax at **617-246-8506**; or email at **MedicareAdvantageRXAppeals@bcbsma.com**. You can file a grievance in person, by mail, fax, email, or you can call **1-800-200-4255** (TTY: **711**).

If you need help filing a grievance, the Medicare Advantage Appeals and Grievance Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697** (TDD).

Complaint forms are available at **hhs.gov**.

TRANSLATION RESOURCES

Proficiency of Language Assistance Services

English: ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call **1-800-200-4255** (TTY: **711**).

Spanish/Español: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-200-4255** (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-4255** (TTY: **711**).

Chinese/繁體中文: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-200-4255** (TTY: **711**).

French Creole/Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-200-4255** (TTY: **711**).

Vietnamese/Tiếng Việt: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-200-4255** (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-200-4255** (телетайп: **711**).

Arabic/العربية:
ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-200-4255** (هاتف الصم والبكم: **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-200-4255** (TTY: **711**).

French/Français: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-200-4255** (ATS: **711**).

Italian/Italiano: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-200-4255** (TTY: **711**).

Korean/한국어: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-200-4255** (TTY: **711**) 번으로 전화해 주십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-800-200-4255** (TTY: **711**).

Polish/Polski: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-200-4255** (TTY: **711**).

Hindi/हिंदी : ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-200-4255** (TTY: **711**)पर कॉल करें।

Gujarati/ગુજરાતી : સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છ. ફોન કરા **1-800-200-4255** (TTY: **711**)

QUESTIONS?

Medicare Plan Sales
1-800-678-2265 (TTY: 711)

Medicare Member Service
1-800-200-4255 (TTY: 711)

April 1 through September 30, 8:00 a.m. to 8:00 p.m. ET, Monday through Friday.

October 1 through March 31, 8:00 a.m. to 8:00 p.m. ET, seven days a week.

bluecrossma.com/medicare

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.

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