ABALOPARATIDE (TYMLOS)

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF THE PATIENT HAS ANY OF THE FOLLOWING CONTRAINDICATIONS: DIAGNOSIS OF PAGET'S DISEASE OF BONE, OPEN EPIPHYSES, BONE METASTASES OR SKELETAL MALIGNANCIES, HEREDITARY DISORDERS PREDISPOSING TO OSTEOSARCOMA, PRIOR EXTERNAL BEAM OR IMPLANT RADIATION THERAPY INVOLVING THE SKELETON, HISTORY OF HYPERCALCEMIA OR HYPERPARATHYROIDISM. NOT APPROVED IF THE PATIENT HAS ANY OF THE FOLLOWING CONTRAINDICATIONS: DIAGNOSIS OF PAGET'S DISEASE OF BONE, OPEN EPIPHYSES, BONE METASTASES OR SKELETAL MALIGNANCIES, HEREDITARY DISORDERS PREDISPOSING TO OSTEOSARCOMA, PRIOR EXTERNAL BEAM OR IMPLANT RADIATION THERAPY INVOLVING THE SKELETON, HISTORY OF HYPERCALCEMIA OR HYPERPARATHYROIDISM

REQUIRED MEDICAL INFORMATION
CURRENT BMD RESULTS (LESS THAN 2 YEARS OLD) SHOWING OSTEOPOROSIS (T-SCORE -2.5 OR LOWER), TRIAL AND FAILURE OR CONTRAINDICATION TO BISPHOSPHONATE THERAPY AND DENOSUMAB

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS
OTHER CRITERIA

RENEWAL CRITERIA: NOT APPROVED FOR MORE THAN 2 YEARS TOTAL (INCLUDING USE OF PARATHYROID HORMONE ANALOGS SUCH AS FORTEO)
ABEMACICLIB (VERZENIO)

MEDICATION(S)
VERZENIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ABIRATERONE (ZYTIGA)

MEDICATION(S)
ABIRATERONE ACETATE, ZYTIGA 500 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANDROGEN RECEPTOR INHIBITOR (E.G. ERLEADA, XTANDI).

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ABIRATERONE, SUBMICRONIZED (YONSA)

**MEDICATION(S)**
YONSA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
METASTATIC CASTRATION RESISTANT PROSTATE CANCER, TO BE USED IN COMBINATION WITH PREDNISONE OR METHYLprednisolone. DOCUMENTATION OF HAVING UNDERGONE BILATERAL ORCHIECTOMY OR CURRENT LHRH AGONIST WITH PSA ELEVATION WHILE ON ANDROGEN DEPRIVATION THERAPY. NON-METASTATIC AND METASTATIC CASTRATION-NAIVE PROSTATE CANCER: BEING USED WITH PREDNISONE AND A GONADOTROPIN-RELEASING HORMONE (GnRH) ANALOG IF NO PRIOR REMOVAL OF THE TESTES (BILATERAL ORCHIECTOMY).

**AGE RESTRICTION**
NOT APPROVED IN PEDIATRIC PATIENTS

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
MEDICATION(S)
CALQUENCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED AS PART OF A MULTI-DRUG CHEMO REGIMEN.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ADALIMUMAB (HUMIRA)

**MEDICATION(S)**
HUMIRA, HUMIRA PEDIATRIC CROHN'S, HUMIRA PEN, HUMIRA PEN CROHN'S-UC-HS, HUMIRA PEN PSOR-UVEITS-ADOL HS, HUMIRA(CF), HUMIRA(CF) PEDIATRIC CROHN'S, HUMIRA(CF) PEN, HUMIRA(CF) PEN CROHN'S-UC-HS, HUMIRA(CF) PEN PSOR-UV-ADOL HS

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
BEING USED WITH ANOTHER TARGETED IMMUNOTHERAPY DRUG.
REQUIRED MEDICAL INFORMATION
SPONDYLOARTHRITIS (SPA): PATIENT IS NOT ABLE TO TAKE NSAIDS DUE TO HISTORY OF GI BLEED OR ULCER OR PATIENT HAS TRIED ONE RX STRENGTH NSAID IN COMBINATION WITH A PPI AND HAD GI SIDE EFFECTS OR PATIENT’S CONDITION DID NOT RESPOND TO A TRIAL OF TWO DIFFERENT RX STRENGTH NSAIDS.
CROHN’S DISEASE (CD), WEEKLY DOSING: PATIENT HAS TRIED EVERY OTHER WEEK DOSING AND HAD A FLARE OR LOSS IN RESPONSE.
HIDRADENITIS SUPPURATIVA (HS): PATIENT HAS HURLEY STAGE II OR III HS.
NON-INFECTIONOUS UVEITIS: PATIENT HAS TRIED A SYSTEMIC CORTICOSTEROID (E.G. PREDNISONE, DEXAMETHASONE, HYDROCORTISONE) OR HAS A MEDICAL REASON WHY CORTICOSTEROIDS CANNOT BE USED.
PLAQUE PSORIASIS (PSO), INITIAL USE: PATIENT HAS TRIED ONE DMARD OR HAS A MEDICAL REASON WHY METHOTREXATE (MTX), CYCLOSPORINE, AND ACITRETIN CANNOT BE USED AND BASELINE PASI SCORE 10 OR MORE OR BSA 3% OR MORE OR SENSITIVE AREAS ARE INVOLVED OR DISEASE AFFECTS DAILY LIVING. ONGOING USE: PASI OR BSA IMPROVED ON HUMIRA.
JUVENILE IDIOPATHIC ARTHRITIS (JIA): PATIENT HAS TRIED ONE DMARD OR HAS A MEDICAL REASON WHY MTX CANNOT BE USED.
PSORIATIC ARTHRITIS (PSA): PATIENT HAS TRIED ONE DMARD OR HAS A MEDICAL REASON WHY MTX, LEFLUNOMIDE, AND SULFASALAZINE CANNOT BE USED.
RHEUMATOID ARTHRITIS (RA): PATIENT HAS TRIED ONE DMARD OR HAS MEDICAL REASON WHY MTX, HYDROXYCHLOROQUINE, AND SULFASALAZINE CANNOT BE USED.
ULCERATIVE COLITIS (UC): PATIENT HAS TRIED A CORTICOSTEROID (E.G. PREDNISONE) OR AN IMMUNOMODULATOR (E.G. AZATHIOPRINE).

AGE RESTRICTION
PLAQUE PSORIASIS: 18 YEARS OF AGE OR OLDER. JIA: 2 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
RA, PSA, JIA, AS: RHEUMATOLOGIST. PSO: RHEUMATOLOGIST OR DERMATOLOGIST. HS: DERMATOLOGIST. NON-INFECTIONOUS UVEITIS: OPHTHALMOLOGIST.

COVERAGE DURATION
PSO, INITIAL: 16 WEEKS - ONGOING USE: 12 MONTHS ALL OTHER INDICATIONS: 12 MONTHS

OTHER CRITERIA
N/A
ADEFOVIR (HEPSERA)

MEDICATION(S)
ADEFOVIR DIPIVOXIL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HBSAG POSITIVE FOR LONGER THAN SIX MONTHS, SERUM HBV DNA POSITIVE, PERSISTENT OR INTERMITTENT ELEVATION OF ALT/AST.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST OR HEPATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
ADO-TRASTUZUMAB EMTANSINE (KADCYLA)

MEDICATION(S)
KADCYLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
BREAST CANCER: CANCER IS HER2 POSITIVE CONFIRMED BY AN FDA APPROVED TEST AND BEING USED AS A SINGLE AGENT AFTER SURGERY (ADJUVANT) FOR EARLY BREAST CANCER THAT HAS BEEN TREATED WITH CANCER DRUG THERAPY BEFORE SURGERY (NEOADJUVANT) AND THERE IS RESIDUAL DISEASE THAT IS REMOVED BY THE SURGERY OR CANCER THAT HAS COME BACK (RECURRENT) OR SPREAD (METASTATIC) AFTER PRIOR TRASTUZUMAB THERAPY (FOR EARLY OR ADVANCED DISEASE).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
AFATINIB DIMALEATE (GILOTRIF)

MEDICATION(S)
GILOTRIF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ALECTINIB (ALECENSA)

MEDICATION(S)
ALECENSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ALISKIREN (TEKTURNA)

MEDICATION(S)
ALISKIREN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF PREVIOUS TREATMENT FAILURE OF 1 ACE INHIBITOR AND 1 ARB AGENT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ALISKIREN/HYDROCHLOROTHIAZIDE (TEKTURNA HCT)

MEDICATION(S)
TEKTURNA HCT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF PREVIOUS TREATMENT FAILURE OF 1 ACE INHIBITOR AND 1 ARB AGENT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ALITRETINOIN (PANRETIN)

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT NEEDS CHEMOTHERAPY FOR KAPOSI'S SARCOMA.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ALOSETRON (LOTRONEX)

**MEDICATION(S)**
ALOSETRON HCL

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D), INITIAL USE: PATIENT IS FEMALE, AND CONDITION DID NOT GET BETTER WITH USE OF AN ANTISPASMODIC OR ANTI-DIARRHEAL DRUG. ONGOING USE: IBS SYMPTOMS IMPROVED WITH ALOSETRON AND PATIENT DOES NOT HAVE CONSTIPATION PROBLEMS.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
INITIAL: 2 MONTHS
ONGOING USE: 12 MONTHS

**OTHER CRITERIA**
N/A
ALPELISIB (PIQRAY)

MEDICATION(S)
PIQRAY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used by itself or with another drug that is not fulvestrant.

REQUIRED MEDICAL INFORMATION
Postmenopausal woman or man with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer that has come back or spread to other areas while on or after hormone therapy and has tested positive for an abnormal PIK3CA gene.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
AMBRISENTAN (LETAIRIS)

MEDICATION(S)
AMBRISENTAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER ENDOTHELIN-RECEPTOR ANTAGONIST (E.G. TRACLEER, OPU SUMIT).

REQUIRED MEDICAL INFORMATION
CONFIRMATION OF PULMONARY ARTERIAL HYPERTENSION (WHO GROUP I) BY RIGHT HEART CATHETERIZATION TEST.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ANAKINRA  (KINERET)

MEDICATION(S)
KINERET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
CONCURRENT USE WITH HUMIRA, ENBREL, REMICADE, CIMZIA, OR SIMPONI OR HAS ACTIVE INFECTION

REQUIRED MEDICAL INFORMATION

AGE RESTRICTION
FOR RA, APPROVED IF 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR PEDIATRICIAN

COVERAGE DURATION
6 MONTHS INITIALLY, THEN 12 MONTHS

OTHER CRITERIA
FOR RA: RENEW AUTHORIZATION IF THERE IS IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT OR IF PATIENT IS STABLE ON THE MEDICATION
APALUTAMIDE (ERLEADA)

MEDICATION(S)
ERLEADA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANDROGEN RECEPTOR INHIBITOR (XTANDI, ZYTIGA).

REQUIRED MEDICAL INFORMATION
NON-METASTATIC DISEASE CONFIRMED BY CT, MRI, PET/CT OR PET/MRI AND PSA DOUBLING TIME IS LESS THAN OR EQUAL TO 10 MONTHS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
APOMORPHINE (APOKYN)

**MEDICATION(S)**
APOKYN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
BEING USED WITH A 5HT3 ANTAGONIST DRUG (E.G. ONDANSETRON, ALOSETRON).

**REQUIRED MEDICAL INFORMATION**
LOSS OF CONTROL OF BODY MOVEMENTS DUE TO ADVANCED PARKINSON’S DISEASE (HYPOMOBILITY): USING AT LEAST TWO ANTIPARKINSONIAN DRUGS, ONE OF WHICH IS LEVODOPA/CARBIDOPA AND BEING USED WITH AN ANTI-EMETIC DRUG (E.G. TRIMETHOBENZAMIDE).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
NEUROLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
APREMILAST (OTEZLA)

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DX OF PSORIATRIC ARTHRITIS. TRIAL AND FAILURE OR INTOLERABLE SIDE EFFECT TO AT LEAST 1 DMARD (E.G. METHOTREXATE, LEFLUNOMIDE, SULFASALAZINE) DX OF MODERATE TO SEVERE PLAQUE PSORIASIS, TRIAL AND FAILURE OR INTOLERABLE SIDE EFFECTS TO AT LEAST ONE TOPICAL AGENT (EITHER CALCIPOTRIENE OR TazorAC) AND ONE DMARD (ACITRETIN, METHOTREXATE, OR CYCLOSPORINE) ORAL ULCERS DUE TO BEHCET'S DISEASE (BD): TRIAL OF AT LEAST ONE OTHER DRUG USED TO TREAT BD (E.G. TOPICAL STEROID, SUCRALFATE, AZATHIOPRINE, COLCHICINE). ORAL ULCERS DUE TO BEHCET'S DISEASE (BD): TRIAL OF AT LEAST ONE OTHER DRUG USED TO TREAT BD (E.G. TRIAMCINOLONE PASTE, SUCRALFATE, AZATHIOPRINE, COLCHICINE).

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
PSA, PSO, RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
APREPITANT (EMEND)

**MEDICATION(S)**
APREPITANT 40 MG CAPSULE, EMEND 125 MG POWDER PACKET

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTATION OF DIAGNOSIS (CHEMOTHERAPY ASSOCIATED OR POST OPERATIVE NAUSEA AND VOMITING), AS WELL AS DOCUMENTATION OF NOT RESPONDING TO ONDANSETRON OR GRANISETRON

**AGE RESTRICTION**
FOR CHEMO INDUCED NAUSEA: CAPSULES NOT APPROVED IF LESS THAN 12 YEARS OF AGE.
FOR POST-OP NAUSEA: NOT APPROVED IF LESS THAN 18 YEARS OF AGE

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
LENGTH OF THERAPY

**OTHER CRITERIA**
NOT APPROVED IF COVERED UNDER PART B
ARIPIPRAZOLE  (ABILIFY MAINTENA)

MEDICATION(S)
ABILIFY MAINTENA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
OLDER ADULTS (65 YEARS AND OLDER) WITH DEMENTIA-RELATED PSYCHOSIS.

REQUIRED MEDICAL INFORMATION
TREATMENT FAILURE WITH AT LEAST ONE ORAL ATYPICAL ANTIPSYCHOTIC (RISPERIDONE, ZIPRASIDONE, QUETIAPINE, OLANZAPINE, ARIPIPRAZOLE).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ARIPIPRAZOLE LAUROXIL (ARISTADA)

MEDICATION(S)
ARISTADA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
OLDER ADULTS (65 YEARS AND OLDER) WITH DEMENTIA-RELATED PSYCHOSIS.

REQUIRED MEDICAL INFORMATION
TREATMENT FAILURE WITH AT LEAST ONE ORAL ATYPICAL ANTIPSYCHOTIC (RISPERIDONE, ZIPRASIDONE, QUETIAPINE, OLANZAPINE, ARIPIPRAZOLE).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
SCHIZOPHRENIA: PSYCHIATRIST

COVERAGE DURATION
ARISTADA: 12 MONTHS

OTHER CRITERIA
N/A
**ARIPIPRAZOLE LAUROXIL, SUBMICRONIZED (ARISTADA INITIO)**

**MEDICATION(S)**
ARISTADA INITIO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
OLDER ADULTS (65 YEARS AND OLDER) WITH DEMENTIA-RELATED PSYCHOSIS.

**REQUIRED MEDICAL INFORMATION**
TREATMENT FAILURE WITH AT LEAST ONE ORAL ATYPICAL ANTIPSYCHOTIC (RISPERIDONE, ZIPRASIDONE, QUETIAPINE, OLANZAPINE, ARIPIPRAZOLE).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
SCHIZOPHRENIA: PSYCHIATRIST

**COVERAGE DURATION**
ARISTADA INITIO: ONE TIME TO START/RESTART ARISTADA TREATMENT

**OTHER CRITERIA**
ARISTADA INITIO: SINGLE USE ALONG WITH ORAL ARIPIPRAZOLE
ASENAPINE (SAPHRIS)

MEDICATION(S)
SAPHRIS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF: ELDERLY (65 YEARS OLD AND OLDER) PATIENT WITH DEMENTIA RELATED PSYCHOSIS, KNOWN SENSITIVITY TO ANY EXCIPIENTS IN THE FORMULATION, OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH C)

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE ON A FORMULARY ATYPICAL ANTIPSYCHOTIC SUCH AS: RISPERIDONE, ARIPRIAZOLE ZIPRASIDONE, QUETIAPINE, OLANZAPINE

AGE RESTRICTION
NOT APPROVED: IF LESS THAN 10 YEARS OLD FOR ACUTE MONOTHERAPY OF MANIC OR MIXED EPISODES OF BIPOLAR DISORDER, OR LESS THAN 18 YEARS OLD FOR SCHIZOPHRENIA, OR AS ADJUNCTIVE TREATMENT TO LITHIUM OR VALPROATE, OR MAINTENANCE MONOTHERAPY IN BIPOLAR DISORDER

PRESCRIBER RESTRICTION
PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ASENAPINE (SECUADO)

MEDICATION(S)
SECUADO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Side effect to asenapine sublingual tablet (Saphris) that is not expected with Secuado.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
ASPARAGINASE (ERWINAZE)

MEDICATION(S)
ERWINAZE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ACUTE LYMPHOBLASTIC LEUKEMIA AND DOCUMENTATION OF SEVERE HYPERSENSITIVITY REACTION TO E COLI DERIVED ASPARAGINASE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B
ATEZOLIZUMAB (TECENTRIQ)

MEDICATION(S)
TECENTRIQ 1,200 MG/20 ML VIAL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN) GUIDELINES AND FDA LABELING.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH FDA LABELING AND CURRENT NCCN GUIDELINES.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON FDA LABELING AND CURRENT NCCN GUIDELINES.

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
AVAPRITINIB (AYVAKIT)

**MEDICATION(S)**
AYVAKIT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Documentation that confirms a certain type of stomach, bowel, or esophagus cancer called gastrointestinal stromal tumor (GIST) which cannot be treated with surgery or has spread to other parts of the body (metastatic), and is caused by certain abnormal platelet-derived growth factor receptor alpha (PDGFRA) genes.

**AGE RESTRICTION**
18 years of age or older

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

**OTHER CRITERIA**
N/A
AVATROMBOPAG (DOPTELET)

MEDICATION(S)
DOPTELET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF CURRENTLY USING OTHER THROMBOPOIETIN RECEPTOR AGONISTS SUCH AS ROMIPLOSTIN OR ELTROMBOPAG

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF THROMBOCYTOPENIA IN PATIENT WITH CHRONIC LIVER DISEASE (CLD) AND SCHEDULED TO UNDERGO A MEDICAL OR DENTAL PROCEDURE. BASELINE PLATELET COUNT IN THE LAST 30 DAYS LESS THAN 50 X 10^9/L

CHRONIC IMMUNE THROBOCYTOPENIA (ITP), INITIAL USE: PLATELET COUNT IS LESS THAN 30 X 10^9/L CELLS/MCL AND OTHER TREATMENTS LIKE CORTICOSTEROIDS, IVIG, ANTI-D ANTIBODY, AND SPLENECTOMY HAVE NOT WORKED WELL ENOUGH.

ITP, ONGOING USE: PLATELET COUNT HAS INCREASED SINCE STARTING DOPTETELET OR PLATELET COUNT HAS NOT WORSENED AND THERE HAVE BEEN NO SIGNS OF SIGNIFICANT BLEEDING.

AGE RESTRICTION
NOT APPROVED IF PATIENT UNDER 18 YEARS OLD

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CLD: 1 FILL (#15 OF 20 MG TABLETS)
ITP: initial 3 months, ongoing 6 months

OTHER CRITERIA
N/A
AVELUMAB (BAVENCIO)

MEDICATION(S)
BAVENCIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN) GUIDELINES AND FDA LABELING.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH FDA LABELING AND CURRENT NCCN GUIDELINES.

AGE RESTRICTION
12 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON FDA LABELING AND CURRENT NCCN GUIDELINES.

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
AXITINIB (INLYTA)

MEDICATION(S)
INLYTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
AZTREONAM LYSINE (CAYSTON)

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF CYSTIC FIBROSIS AND PSEUDOMONAS AERUGINOSA INFECTION IDENTIFIED BY CULTURE REPORT

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
BECAPLERMIN (REGRANEX)

MEDICATION(S)
REGRANEX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
TREATING PRESSURE ULCERS OR VENOUS STASIS ULCERS.

REQUIRED MEDICAL INFORMATION
DIABETIC ULCER HAS NOT RESPONDED TO STANDARD THERAPY FOR WOUND MANAGEMENT (I.E. DEBRIDEMENT, DRESSING CHANGES, PRESSURE RELIEF).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
N/A
BENDAMUSTINE (BENDEKA)

MEDICATION(S)
BENDEKA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
BENDAMUSTINE (TREANDA)

**MEDICATION(S)**
TREANDA 100 MG VIAL, TREANDA 25 MG VIAL

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
EXCLUDED UNDER PART D IF COVERED BY PART B.
BINIMETINIB (MEKTOVI)

MEDICATION(S)
MEKTOVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
DISEASE PROGRESSED ON PRIOR TREATMENT WITH A BRAF AND/OR MEK INHIBITOR.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
**BOSENTAN (TRACLEER)**

**MEDICATION(S)**
BOSENTAN, TRACLEER 32 MG TABLET FOR SUSP

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
BEING USED WITH ANOTHER ENDOTHELIN-RECEPTOR ANTAGONIST (OPSUMIT, AMBRISENTAN).

**REQUIRED MEDICAL INFORMATION**
CONFIRMATION OF PULMONARY ARTERIAL HYPERTENSION (WHO GROUP I) BY RIGHT HEART CATHETERIZATION TEST.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
BOSUTINIB (BOSULIF)

MEDICATION(S)
BOSULIF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ACUTE LYMPHOBLASTIC LEUKEMIA (ALL): PHILADELPHIA CHROMOSOME POSITIVE, AND HAS A MEDICAL REASON NOT TO USE IMATINIB.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
BREXIPRAZOLE (REXULTI)

**MEDICATION(S)**
REXULTI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
FOR DX OF SCHIZOPHRENIA: TRIAL AND FAILURE OR DOCUMENTED CONTRAINDICATION TO 2 FORMULARY ATYPICAL ANTIPSYCHOTICS (ARIPIPRAZOLE, RISPERIDONE, ZIPRASIDONE, QUETIAPINE, OLANZAPINE). FOR USE AS ADJUNCTIVE THERAPY TO ANTIDEPRESSANTS FOR THE TX OF MAJOR DEPRESSIVE DISORDER: TRIAL AND FAILURE OR DOCUMENTED CONTRAINDICATION TO ARIPIPRAZOLE AND QUETIAPINE.

**AGE RESTRICTION**
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

**PRESCRIBER RESTRICTION**
PSYCHIATRIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
BRIGATINIB (ALUNBRIG)

MEDICATION(S)
ALUNBRIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED AS PART OF A MULTI-DRUG CHEMO REGIMEN.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
PATIENT IS 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
BRIVARACETAM  (BRIVIACT INJECTABLE)

**MEDICATION(S)**
BRIVIACT 50 MG/5 ML VIAL

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DIAGNOSIS OF PARTIAL ONSET SEIZURES IN PATIENT WITH EPILEPSY WITH CONFIRMED TEMPORARY INABILITY TO USE ORAL AGENTS AND DOCUMENTATION OF TRIAL AND FAILURE ON OR CONTRAINDICATION TO IV LEVETIRACETAM. IF ABOVE CONDITIONS ARE MET WILL BE APPROVED AS ADJUNCT THERAPY ONLY AND ONLY UNTIL ORAL ADMINISTRATION CAN BE FEASIBLE.

**AGE RESTRICTION**
NOT APPROVED IF LESS THAN 16 YEARS OF AGE

**PRESCRIBER RESTRICTION**
NEUROLOGIST

**COVERAGE DURATION**
90 DAYS

**OTHER CRITERIA**
NOT APPROVED IF COVERED UNDER PART B
BRIVARACETAM (BRIVIACT)

**MEDICATION(S)**
BRIVIACT 10 MG TABLET, BRIVIACT 10 MG/ML ORAL SOLN, BRIVIACT 100 MG TABLET, BRIVIACT 25 MG TABLET, BRIVIACT 50 MG TABLET, BRIVIACT 75 MG TABLET

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DIAGNOSIS OF PARTIAL ONSET SEIZURES IN PATIENT WITH EPILEPSY AND DOCUMENTATION OF TRIAL AND FAILURE ON OR CONTRAINDICATION TO LEVETIRACETAM AND ONE OTHER FORMULARY FIRST LINE ANTI-EPILEPTIC INDICATED FOR PARTIAL SEIZURE DISORDER (SUCH AS CARBAMAZEPINE, PHENYTIN, PHENOBARBITAL, TOPIRAMATE, LAMOTRIGINE, LACOSAMIDE).

**AGE RESTRICTION**
NOT APPROVED IF LESS THAN 4 YEARS OF AGE

**PRESCRIBER RESTRICTION**
NEUROLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
APPROVED AS AN ADJUNCTIVE THERAPY OR MONOTHERAPY
BROMOCRIPTINE MESYLATE (CYCLOSET)

MEDICATION(S)
CYCLOSET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF PATIENT HAS A CONTRAINDICATION TO BROMOCRIPTINE THERAPY SUCH AS HYPERSENSITIVITY OR HISTORY OF SYNCOPAL MIGRAINES. NOT APPROVED IF CONCOMITANT INSULIN THERAPY.

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF TRIAL AND FAILURE OR CONTRAINDICATION FOR THE USE OF METFORMIN AND 1 OF THE FOLLOWING: SULFONYLUREA, TZD, DPP4 INHIBITOR.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
BUDESONIDE (BUDESONIDE)

MEDICATION(S)
BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ASTHMA

AGE RESTRICTION
NOT APPROVED IF OLDER THAN 8 YEARS UNLESS MEDICALLY ACCEPTED

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B
C1 ESTERASE INHIBITOR (HAEGARDA)

**MEDICATION(S)**
HAEGARDA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
BEING USED WITH OTHER HEREDITARY ANGIOEDEMA (HAE) PREVENTIVE THERAPIES (E.G. DANAZOL, CINRYZE).

**REQUIRED MEDICAL INFORMATION**
PREVENTION: CHART DOCUMENTATION OR LABS THAT SHOW C4 AND C1-INH (ANTIGENIC OR FUNCTIONAL) LEVELS CONFIRM HAE TYPE I OR II, AND PATIENT HAS A HISTORY OF FREQUENT OR SEVERE ATTACKS (I.E. MORE THAN ONE ATTACK PER MONTH, ATTACKS WITH LARYNGEAL/UPPER AIRWAY INVOLVEMENT OR THAT IMPAIR DAILY LIVING)

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
**C1 ESTERASE INHIBITOR, RECOMBINANT** (RUCONEST)

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<tr>
<td>OTHER CRITERIA</td>
<td>N/A</td>
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</table>
CABOZANTINIB (CABOMETYX)

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HEPATOCELLULAR CARCINOMA (LIVER CANCER): BEING USED AS A SINGLE AGENT AND PATIENT HAS HAD PRIOR THERAPY FOR LIVER CANCER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CABOZANTINIB S-MALATE (COMETRIQ)

MEDICATION(S)
COMETRIQ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Cancer can be removed by surgery

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CANNABIDIOIL (CBD) EXTRACT (EPIDIOLEX)

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DRAVET SYNDROME: TRIAL OF TWO OF THE FOLLOWING ANTI-SEIZURE DRUGS: VALPROIC ACID, TOPIRAMATE, LEVETIRACETAM, AND CLOBAZAM.
LENNOX-GASTAUT SYNDROME: TRIAL OF TWO OF THE FOLLOWING ANTI-SEIZURE DRUGS: CLONAZEPAM, FELBAMATE, LAMOTRIGINE, TOPIRAMATE, AND VALPROIC ACID.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CARFILZOMIB (KYPROLIS)

MEDICATION(S)
KYPROLIS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED SIDE EFFECT OR MEDICAL REASON NOT TO USE VELCADE (BORTEZOMIB) FOR INITIAL TREATMENT OF MULTIPLE MYELOMA OR WALDENSTROMS MACROGLOBULINEMIA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
CARGLUMIC ACID (CARBAGLU)

MEDICATION(S)
CARBAGLU

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CARIPRAZINE HYDROCHLORIDE (VRAYLAR)

MEDICATION(S)
VRAYLAR 1.5 MG CAPSULE, VRAYLAR 3 MG CAPSULE, VRAYLAR 4.5 MG CAPSULE, VRAYLAR 6 MG CAPSULE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF REQUEST IS FOR THE TREATMENT OF DEMENTIA RELATED PSYCHOSIS

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE OR DOCUMENTED CONTRAINDICATION TO 2 FORMULARY ATYPICAL ANTIPSYCHOTICS INDICATED FOR SCHIZOPHRENIA AND BIPOLAR DISORDER (ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE).

AGE RESTRICTION
NOT APPROVED FOR PEDIATRIC PATIENTS

PRESCRIBER RESTRICTION
PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CASPOFUNGIN (CANCIDAS)

**MEDICATION(S)**
CASPOFUNGIN ACETATE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
OROPHARYNGEAL OR ESOPHAGEAL CANDIDIASIS: PATIENT HAS TRIED FLUCONAZOLE OR FUNGAL CULTURE CONFIRMS INFECTION IS RESISTANT TO AZOLE ANTIFUNGALS.
INVASIVE ASPERGILLOSIS: PATIENT HAS TRIED AN ORAL OR IV AZOLE ANTIFUNGAL OR FUNGAL CULTURE CONFIRMS INFECTION IS RESISTANT TO AZOLE ANTIFUNGALS. ANTIFUNGAL PROPHYLAXIS IN CANCER PATIENTS AT HIGH RISK OF FEBRILE NEUTROPENIA [E.G. DUE TO CHEMOTHERAPY REGIMEN, AML/MDS PATIENT, UNDERGOING HCST]: PATIENT HAS TRIED FLUCONAZOLE, VORICONAZOLE, OR POSACONAZOLE OR HAS A MEDICAL REASON (CONTRAINDICATIONS) TO AZOLE ANTIFUNGALS.
PULMONARY ASPERGILLOSIS: PATIENT HAS TRIED ITRACONAZOLE OR VORICONAZOLE

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
2 MONTHS

**OTHER CRITERIA**
ONGOING USE: CONTINUED NEUTROPENIA, CULTURE REMAINS POSITIVE, OR ONGOING SYMPTOMS.
CEMIPLIMAB-RWLC  (LIBTAYO)

MEDICATION(S)
LIBTAYO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT IS A CANDIDATE FOR CURATIVE SURGERY OR RADIATION.
PATIENT HAS HAD PRIOR IMMUNE CHECKPOINT INHIBITOR THERAPY.
BEING USED AS PART OF A MULTI-DRUG REGIMEN.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
CENOBAMATE (XCOPRI)

MEDICATION(S)
XCOPRI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Treatment failure or side effect with two preferred anti-seizure drugs (e.g. carbamazepine, clorazepate, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, tiagabine, topiramate, zonisamide) OR medical reason why preferred anti-seizure drugs cannot be used (contraindication).

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
CERITINIB (ZYKADIA)

MEDICATION(S)
ZYKADIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED AS PART OF A MULTIDRUG CHEMOTHERAPY REGIMEN.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CLOBAZAM (ONFI)

MEDICATION(S)
CLOBAZAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DRAVET SYNDROME: TRIAL OF VALPROIC ACID.
LENNOX-GASTAUT SYNDROME: TRIAL OF TWO OF THE FOLLOWING ANTI-SEIZURE DRUGS: CLONAZEPAM, FELBAMATE, LAMOTRIGINE, TOPIRAMATE, AND VALPROIC ACID.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
**CLOBAZAM ORAL FILM (SYMPAZAN)**

**MEDICATION(S)**
SYMPAZAN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTED FAILURE ON 2 OF THE FOLLOWING FORMULARY FIRST LINE ANTIEPILEPTICS INDICATED FOR LENNOX-GASTAUT SYNDROME: VALPROIC ACID, LAMOTRIGINE, TOPIRAMATE, FELBAMATE. ALSO DOCUMENTED INABILITY TO TAKE TABLET OR SOLUTION FORMULATION

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
NEUROLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
CLONIDINE HCL (KAPVAY)

MEDICATION(S)
CLONIDINE HCL ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TREATMENT FAILURE OR CONTRAINDICATION TO A CNS STIMULANT

AGE RESTRICTION
APPROVED FOR AGES 6 TO 17 YEARS ONLY

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CLOZAPINE (VERSACLOZ)

**MEDICATION(S)**
VERSACLOZ

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
NOT APPROVED IF: ELDERLY (65 YEARS OLD AND OLDER) PATIENT WITH DEMENTIA RELATED PSYCHOSIS, HISTORY OF CLOZAPINE-INDUCED AGRANULOCYTOSIS OR SEVERE GRANULOCYTOPENIA, OR HISTORY OF HYPERSENSITIVITY TO CLOZAPINE

**REQUIRED MEDICAL INFORMATION**
TRIAL AND FAILURE OF 2 ATYPICAL ANTIPSYCHOTIC MEDICATIONS INDICATED FOR PATIENT’S CONDITION INCLUDING CLOZAPINE AND DOCUMENTATION OF INABILITY TO USE ORAL DOSAGE FORM

**AGE RESTRICTION**
NOT APPROVED IF PEDIATRIC PATIENT

**PRESCRIBER RESTRICTION**
PSYCHIATRIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
PATIENT, PHYSICIAN AND PHARMACY MUST BE ENROLLED IN VERSACLOZ PATIENT REGISTRY PROGRAM
COBIMETINIB (COTELLIC)

MEDICATION(S)
COTELLIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
COLESEVELAM HCL (WELCHOL)

MEDICATION(S)
COLESEVELAM HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR THE DIAGNOSIS OF HYPERLIPIDEMIA: CURRENT LIPID PROFILE AND DOCUMENTATION OF TRIAL AND FAILURE OR INTOLERANCE TO HMG-COA REDUCTASE INHIBITOR AND EITHER CHOLESTYRAMINE OR COLESTIPOL. FOR THE DIAGNOSIS OF DIABETES: DOCUMENTATION OF TRIAL AND FAILURE OR INTOLERANCE TO METFORMIN AND A1C BELOW 8.5%

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
COPANLISIB (ALIQOPA)

MEDICATION(S)
ALIQOPA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
CRIZOTINIB (XALKORI)

**MEDICATION(S)**
XALKORI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
NON-SMALL CELL LUNG CANCER (NSCLC): BEING USED AS A SINGLE AGENT AND ONE OF THE FOLLOWING: CANCER TESTED POSITIVE FOR AN ANAPLASTIC LYMPHOMA KINASE (ALK) GENE MUTATION, A ROS1 GENE MUTATION, A HIGH LEVEL MESENCHYMAL-EPIDERMAL TRANSITION (MET) GENE AMPLIFICATION, OR A MET GENE EXON 14 SKIPPING MUTATION.

**AGE RESTRICTION**
18 YEARS OF AGE OR OLDER.

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
CYSTEAMINE (CYSTAGON)

MEDICATION(S)
CYSTAGON

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CYSTEAMINE (CYSTARAN)

**MEDICATION(S)**
CYSTARAN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PREScriber RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
DABRAFENIB (TAFINLAR)

MEDICATION(S)
TAFINLAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ANAPLASTIC THYROID CANCER (ATC): BEING USED WITH MEKINIST TO TREAT CANCER THAT HAS A CHANGE IN THE BRAF GENE CALLED V600E (MUTATION) AND HAS SPREAD LOCALLY OR TO OTHER PARTS OF THE BODY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
DACOMITINIB (VIZIMPRO)

**MEDICATION(S)**
VIZIMPRO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
PATIENT HAS PREVIOUSLY RECEIVED TREATMENT FOR METASTATIC NSCLC.

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
ONCOLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
DALFAMPRIDINE ( AMPYRA )

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MULTIPLE SCLEROSIS, INITIAL USE: SCORED BETWEEN 8-45 SECONDS ON A 25-FOOT WALKING TEST. ONGOING USE: UPDATED TIMED 25-FOOT WALKING TEST SHOWS IMPROVEMENT FROM PRIOR OR BASELINE TEST.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST

COVERAGE DURATION
INITIAL USE: 3 MONTHS
ONGOING USE: 12 MONTHS

OTHER CRITERIA
N/A
DARATUMUMAB (DARZALEX)

**MEDICATION(S)**
DARZALEX

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
EXCLUDED UNDER PART D IF COVERED BY PART B.
DAROLUTAMIDE (NUBEQA)

MEDICATION(S)
NUBEQA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with an androgen receptor inhibitor (e.g. Xtandi, Erleada).

REQUIRED MEDICAL INFORMATION
Prostate cancer: cancer has not spread to other parts of the body (confirmed by CT, MRI, PET/CT or PET/MRI) and no longer responds to medical or surgical treatment that lowers testosterone confirmed by rising PSA levels (castration resistant disease) and being used with a gonadotropin-releasing hormone (GnRH) analog if no prior removal of the testes (bilateral orchiectomy).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
DASATINIB (SPRYCEL)

MEDICATION(S)
SPRYCEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
GASTROINTESTINAL STROMAL TUMOR (GIST): PATIENT’S CANCER DID NOT GET BETTER WITH IMATINIB, SUTENT AND STIVARGA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
DEFERASIROX (EXJADE)

MEDICATION(S)
DEFERASIROX 125 MG TB FOR SUSP, DEFERASIROX 250 MG TB FOR SUSP, DEFERASIROX 500 MG TB FOR SUSP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF CREATININE CLEARANCE LESS THAN 40ML/MIN AND PLATELET COUNT LESS THAN 50 X 10^9 PER LITER

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HEMOGLOBINOPATHY OR SICKLE CELL DISEASE WITH IRON OVERLOAD OR CHRONIC IRON OVERLOAD IN NONTRANSFUSION-DEPENDANT THALASSEMIA SYNDROMES

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
DENOSUMAB (PROLIA)

MEDICATION(S)
PROLIA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CURRENT BMD RESULTS SHOWING TSCORE OF -2.5 OR LESS AND FAILURE OR CONTRAINDICATION TO BISPHOSPHONATE therapy (e.g. alendronate, ibandronate, risedronate, zoledronic acid)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
DENOSUMAB (XGEVA)

MEDICATION(S)
XGEVA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF HYPOCALCEMIA WITH CALCIUM LEVEL LESS THAN 8.5 MG PER DL

REQUIRED MEDICAL INFORMATION
FOR PREVENTION OF SRE IN BONE METS: TRIAL and failure or side effect with bisphosphonate therapy. FOR TX OF GIANT CELL TUMOR OF BONE, DOCUMENTATION THAT THE TUMOR IS UNRESECTABLE OR RESECTION LIKELY TO RESULT IN SEVERE MORBIDITY

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE EXCEPT IN SKELETALLY MATURE ADOLESCENTS WITH GIANT CELL TUMOR OF BONE

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
DESVENLAFAXINE (PRISTIQ)

MEDICATION(S)
DESVENLAFAXINE ER, DESVENLAFAXINE SUCCINATE ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED TREATMENT FAILURE OF ONE FORMULARY SSRI (FLUOXETINE, SETRALINE, CITALOPRAM, PAROXETINE) AND ONE SNRI (VENLAFAXINE, DULOXETINE)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF THE PATIENT HAS ANY OF THE FOLLOWING: CONCOMITANT USE WITH QUININE, QUINIDINE, OR MEFLOQUINE, HISTORY OF QUINIDINE, QUININE OR MEFLOQUINE-INDUCED THROMBOCYTOPENIA, HEPATITIS, OR OTHER HYPERSENSITIVITY REACTIONS, KNOWN HYPERSENSIVITY TO DEXTROMETHORPHAN, USE WITH AN MAOI OR WITHIN 14 DAYS OF STOPPING AN MAOI, PROLONGED QT INTERVAL, CONGENITAL LONG QT SYNDROME, HISTORY SUGGESTIVE OF TORSADES DE POINTES, OR HEART FAILURE, COMPLETE AV BLOCK WITHOUT IMPLANTED PACEMAKER, OR PATIENTS AT HIGH RISK OF COMPLETE AT BLOCK, CONCOMITANT USE WITH DRUGS THAT BOTH PROLONG QT INTERVAL AND ARE METABOLIZED BY CYP2D6 (EG: THIORIDAZINE OR PIMOZIDE)

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PBA AND DIAGNOSTIC TEST RESULTS SUPPORTING THE DX OF PBA SUCH AS CENTER OF NEUROLOGY STUDY -LABILITY SCALE (CNS-LS) RESULT

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
6 MONTHS
OTHER CRITERIA
FOR RE-AUTHORIZATION, THE FOLLOWING ARE NEEDED: DOCUMENTATION OF IMPROVEMENT IN RESPONSE TO THERAPY BASED ON CNS-LS SCORE AFTER 90 DAYS OF TREATMENT AND DOCUMENTATION OF ONGOING CBC, LFT AND CARDIAC MONITORING
DICLOFENAC SODIUM  (SOLARAZE)

MEDICATION(S)
DICLOFENAC SODIUM 3% GEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF PATIENT HAD A CORONARY BYPASS GRAFT (CABG) SURGERY

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF TRIAL AND FAILURE ON TOPICAL FLUOROURACIL AND IMIQUIMOD. IF AFFECTED AREA IS THE FACE OR SCALP, DOCUMENTATION OF TRIAL AND FAILURE ON IMIQUIMOD ONLY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
DERMATOLOGIST

COVERAGE DURATION
90 DAYS

OTHER CRITERIA
N/A
DIHYDROERGOTAMINE MESYLATE (MIGRANAL NASAL SPRAY)

MEDICATION(S)
DIHYDROERGOTAMINE 4 MG/ML SPRY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER TRIPTAN OR ERGOT-TYPE DRUG.

REQUIRED MEDICAL INFORMATION
MIGRAINE HEADACHE: TOTAL NUMBER OF REQUESTED DOSES MATCHES THE AMOUNT NEEDED TO TREAT THE NUMBER OF HEADACHE DAYS PER MONTH, AND PATIENT HAS TRIED at least one PREFERRED TRIPTAN OR HAS A MEDICAL REASON (CONTRAINDICATION) FOR NOT USING TRIPTANS, FOR MORE THAN 8 HEADACHE DAYS PER MONTH: PATIENT IS SEEING A NEUROLOGIST OR HEADACHE SPECIALIST AND CURRENTLY TAKING A MIGRAINE PREVENTION DRUG OR HAS A CONTRAINDICATION TO ALL OF THE FOLLOWING MIGRAINE PREVENTION DRUGS: DIVALPROEX, VALPROATE, TOPIRAMATE, AMITRIPTYLINE, VENLAFAXINE, ATENOLOL, AND NADOLOL.
CLUSTER HEADACHE: TOTAL NUMBER OF REQUESTED DOSES MATCHES THE AMOUNT NEEDED TO TREAT THE NUMBER OF HEADACHE DAYS PER MONTH, AND PATIENT IS CURRENTLY TAKING PROPHYLACTIC DRUGS SUPPORTED FOR PREVENTING CLUSTER HEADACHES INCLUDING PREDNISONE, DEXAMETHASONE, VERAPAMIL, LITHIUM, OR TOPIRAMATE, OR CONTRAINDICATION TO LISTED AGENTS SUPPORTED FOR PREVENTING CLUSTER HEADACHES AND PATIENT TRIED at least one PREFERRED TRIPTAN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CLUSTER HEADACHE: NEUROLOGIST OR HEADACHE SPECIALIST.

COVERAGE DURATION
12 MONTHS
OTHER CRITERIA
N/A
DIMETHYL FUMARATE (TECFIDERA)

MEDICATION(S)
TECFIDERA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH OTHER DISEASE-MODIFYING THERAPIES FOR RELAPSING MULTIPLE SCLEROSIS.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
DINUTUXIMAB (UNITUXIN)

MEDICATION(S)
UNITUXIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
5 CYCLES

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
DRONABINOL (MARINOL)

MEDICATION(S)
DRONABINOL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR AIDS WASTING DIAGNOSIS: DOCUMENTATION OF INVOLUNTARY 10% WEIGHT LOSS WITHIN THE LAST 30 DAYS WITHOUT CONCURRENT ILLNESS OTHER THAN HIV INFECTION

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST OR INFECTIOUS DISEASE SPECIALIST OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL AND FAILURE ON THE FOLLOWING ANTIEMETICS: ONDANSETRON AND GRANISETRON. FOR WEIGHT LOSS IN PATIENTS WITH AIDS: TRIAL AND FAILURE ON MEGESTROL
DRONEDARONE HCL (MULTAQ)

MEDICATION(S)
MULTAQ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF FAILURE TO AMIODARONE OR DOCUMENTED CONTRAINDICATION TO AMIODARONE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CARDIOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NOT APPROVED IF: CLASS IV HEART FAILURE OR CLASS II OR III HEART FAILURE WITH RECENT DECOMPENSATION , OR BRADYCARDIA LESS THAN 50 BPM

EFFECTIVE 07/2020
DROXIDOPA (NORTHERA)

MEDICATION(S)
NORTHERA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ORTHOSTATIC HYPOTENSION IS CAUSED BY PRIMARY ANATOMIC FAILURE SUCH AS PARKINSON’S DISEASE, MULTIPLE SYSTEM NEUROPATHY OR PURE AUTONOMIC FAILURE, DOPAMINE BETA-HYDROXYLASE DEFICIENCY, OR NON-DIABETIC AUTONOMIC NEUROPATHY. FOR ONGOING USE: PATIENT HAS HAD CLINICAL IMPROVEMENT IN SYMPTOMS (I.E. DIZZINESS, LIGHTHEADEDNESS, VISION, WEAKNESS, FATIGUE, CONCENTRATION, HEAD/NECK DISCOMFORT) OR DAILY LIVING ACTIVITIES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CARDIOLOGIST OR NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
DRIZALMA SPRINKLE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation to confirm a swallowing defect that does not allow for the use duloxetine delayed-release capsule.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
DURVALUMAB (IMFINZI)

MEDICATION(S)
IMFINZI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN) GUIDELINES AND FDA LABELING.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH FDA LABELING AND CURRENT NCCN GUIDELINES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON FDA LABELING AND CURRENT NCCN GUIDELINES.

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
DUVELISIB (COPIKTRA)

MEDICATION(S)
COPIKTRA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MARGINAL ZONE LYMPHOMAS: CANCER HAS WORSENED OR DID NOT GET BETTER AFTER USING TWO NCCN SUPPORTED CANCER DRUG REGIMENS.
CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) OR SMALL LYMPHOCYTIC LYMPHOMA (SLL): CANCER HAS WORSENED OR DID NOT GET BETTER AFTER USING AT LEAST ONE OTHER NCCN SUPPORTED CANCER DRUG REGIMEN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ELEXACAFTOR/TEZACAFTOR/IVACAFTOR (TRIKAFTA)

MEDICATION(S)
TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another CFTR modulator agent (e.g. Kalydeco, Symdeko, Orkambi)

REQUIRED MEDICAL INFORMATION
Documentation that confirms there is at least one copy of F508del mutation in the CFTR gene.

AGE RESTRICTION
12 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
ELOTUZUMAB (EMPLICITI)

MEDICATION(S)
EMPLICITI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
MEDICATION(S)
PROMACTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
CHRONIC IDIOPATHIC THROMBOCYTOPENIC PURPURA (ITP): BEING USED WITH ANOTHER THROMBOPOIETIN RECEPTOR AGONIST (TPO-RA).
MDS: BEING USED IN HIGH-RISK MDS

REQUIRED MEDICAL INFORMATION
TREATMENT OF LOW PLATELET COUNTS (THROMBOCYTOPENIA) DUE TO CHRONIC HEPATITIS C INTERFERON-BASED THERAPY: PLATELET COUNT IS LESS THAN OR EQUAL TO 75,000/MCL PRIOR TO THERAPY OR FALLS TO LESS THAN OR EQUAL TO 50,000/MCL DURING THERAPY.
CHRONIC ITP, INITIAL: PLATELET COUNT IS LESS THAN 30,000/MCL, AND PATIENT HAD A SIDE EFFECT OR DID NOT RESPOND WELL ENOUGH ONE OF THE FOLLOWING TREATMENTS: CORTICOSTEROIDS, IVIG, ANTI-D, AND SPLENECTOMY OR HAS A MEDICAL REASON NOT TO USE (CONTRAINDICATION) CORTICOSTEROIDS, IVIG, AND ANTI-D.
APLASTIC ANEMIA, FIRST TREATMENT: WILL BE USED WITH CYCLOSPORINE AND ANTITHYMCYTE GLOBULIN (ATG) THERAPY.
REFRACTORY APLASTIC ANEMIA: PLATELET COUNT IS LESS THAN 50,000 CELLS/MCL AND PATIENT DID NOT RESPOND WELL ENOUGH TO CYCLOSPORINE AND ATG THERAPY.
THROMBOCYTOPENIA DUE TO MDS: TREATMENT FAILURE OR NO RESPONSE TO AT LEAST ONE HYPOMETHYLATING DRUG (E.G. DECITABINE, AZACITIDINE), ATG, OR CYCLOSPORINE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A
COVERAGE DURATION
ITP, INITIAL: 3 MONTHS
ALL OTHER CONDITIONS: 6 MONTHS
ONGOING USE: 6 MONTHS

OTHER CRITERIA
ONGOING USE: PLATELET COUNT IS MORE THAN OR EQUAL TO 50,000/MCL AND LESS THAN OR EQUAL TO 400,000/MCL AND FOR MDS ONLY DISEASE HAS NOT PROGRESSED TO ACUTE LEUKEMIA.
ENASIDENIB MESYLATE (IDHIFA)

MEDICATION(S)
IDHIFA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
AML: 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ENCORAFENIB (BRAFTOVI)

**MEDICATION(S)**
BRAFTOVI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
COLON OR RECTAL CANCER: DISEASE HAS SPREAD TO OTHER AREAS (METASTATIC) OR CANNOT BE REMOVED BY SURGERY (UNRESECTABLE) AND CANCER IS DUE TO A CHANGE IN THE BRAF GENE CALLED V600E AND PART OF A MULTIDRUG REGIMEN THAT CONTAINS EITHER CETUXIMAB OR PANITUMUMAB.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
ENTECAVIR (BARAACLEDE)

MEDICATION(S)
BARAACLEDE 0.05 MG/ML SOLUTION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HBSAG POSITIVE FOR LONGER THAN SIX MONTHS, SERUM HBV DNA POSITIVE, PERSISTENT OR INTERMITTENT ELEVATION OF ALT/AST, LIVER BIOPSY SHOWING CHRONIC HEPATITIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
6 MONTHS, 12 MONTHS FOR REAUTHORIZATIONS

OTHER CRITERIA
N/A
ENTRECTORINIB (ROZLYTREK)

MEDICATION(S)
ROZLYTREK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Part of a multi-drug anti-cancer regimen

REQUIRED MEDICAL INFORMATION
Non-small Cell Lung Cancer (NSCLC): cancer has spread to other parts of the body and is caused by a change in the ROS1 gene.
Solid Tumors: cancer is caused by changes in the NTRK genes AND has spread or is unable to be removed by surgery without complications AND no satisfactory treatment options exist or the cancer grew or spread on other treatment.

AGE RESTRICTION
NSCLC: 18 years of age or older
Solid Tumors: 12 years of age of older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
ENZALUTAMIDE (XTANDI)

**MEDICATION(S)**
XTANDI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Prostate cancer, castration-naïve: disease has spread to other areas of the body (metastatic) and being used with a gonadotropin-releasing hormone (GnRH) analog if no prior removal of the testes (bilateral orchiectomy).
Prostate cancer, castration-resistant: prior LHRH/GnRH analog therapy (e.g. Zoladex, leuprolide) or bilateral orchiectomy AND metastatic disease or non-metastatic confirmed by imaging study and rising PSA levels despite ADT therapy.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
EPOETIN ALFA (PROCRIT)

MEDICATION(S)
PROCRIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR DIAGNOSIS OF ANEMIA DUE TO CRF, ZIDOVUDINE-TREATED HIV-INFECTED PATIENTS OR CANCER PATIENTS ON CHEMOTHERAPY: HEMOGLOBIN OF LESS THAN OR EQUAL TO 10GM/DL, OR HEMATOCRIT OF LESS THAN OR EQUAL TO 30%. FOR REDUCTION OF ALLOGENEIC BLOOD TRAFNSFUSION IN SURGERY PATIENTS WITH A HEMOGLOBIN GREATER THAN 10 BUT LESS THAN 13GM/DL, WILL NOT APPROVE IF SURGICAL PATIENT IS WILLING TO DONATE AUTOLOGOUS BLOOD.

MDS, INITIAL USE: HGB IS LESS THAN OR EQUAL TO 10G/ DL OR HCT IS LESS THAN OR EQUAL TO 30% (SYMPTOMATIC ANEMIA), AND EPO LEVEL IS LESS THAN OR EQUAL TO 500U/ML. ONGOING USE: CURRENT HGB IS LESS THAN OR EQUAL TO 12G/ DL OR HCT IS LESS THAN OR EQUAL TO 36%, AND HGB ROSE AT LEAST 1.5G/ DL OR REDUCED NUMBER OF BLOOD TRANSFUSIONS SINCE STARTING PROCRIT.

ANEMIA DUE TO RA, INITIAL: CURRENT HGB LESS THAN OR EQUAL TO 10G/ DL OR HCT LESS THAN OR EQUAL TO 30%, AND ANEMIA IS NOT ACUTE OR CAUSED BY CORRECTABLE ETIOLOGY (E.G. OCCULT BLOOD LOSS DUE TO GASTRITIS). ONGOING USE: CURRENT HGB IS 12 G/ DL OR LESS OR HCT IS 36% OR LOWER.

HEPATITIS C ON RIBAVIRIN THERAPY: AT LEAST A 3 G/ DL DROP IN HGB WITHIN ONE MONTH ON RIBAVIRIN, OR HGB IS 12 G/ DL OR LESS OR HCT IS 36% OR LOWER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A
COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B
EPOETIN ALFA-EPBX (RETACRIT)

MEDICATION(S)
RETACRIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR DIAGNOSIS OF ANEMIA DUE TO CRF, ZIDOVUDINE-TREATED HIV-INFECTED PATIENTS OR CANCER PATIENTS ON CHEMOTHERAPY: HEMOGLOBIN OF LESS THAN OR EQUAL TO 10GM/DL, OR HEMATOCRIT OF LESS THAN OR EQUAL TO 30%.
REDUCTION OF ALLOGENEIC BLOOD TRANSFUSION IN SURGERY PATIENTS WITH A HEMOGLOBIN GREATER THAN 10 BUT LESS THAN 13GM/DL, WILL NOT APPROVE IF SURGICAL PATIENT IS WILLING TO DONATE AUTOLOGOUS BLOOD.
MDS, INITIAL USE: HGB IS LESS THAN OR EQUAL TO 10G/DL OR HCT IS LESS THAN OR EQUAL TO 30% (SYMPTOMATIC ANEMIA), AND EPO LEVEL IS LESS THAN OR EQUAL TO 500U/ML.
ONGOING USE: CURRENT HGB IS LESS THAN OR EQUAL TO 12G/DL OR HCT IS LESS THAN OR EQUAL TO 36%, AND HGB ROSE AT LEAST 1.5G/DL OR REDUCED NUMBER OF BLOOD TRANSFUSIONS SINCE STARTING RETACRIT.
ANEMIA DUE TO RA, INITIAL: CURRENT HGB LESS THAN OR EQUAL TO 10 G/DL OR HCT LESS THAN OR EQUAL TO 30%, AND ANEMIA IS NOT ACUTE OR CAUSED BY CORRECTABLE ETIOLOGY (E.G. OCCULT BLOOD LOSS DUE TO GASTRITIS). ONGOING USE: CURRENT HGB IS 12 G/DL OR LESS OR HCT IS 36% OR LOWER.
HEPATITIS C ON RIBAVIRIN THERAPY: AT LEAST A 3 G/DL DROP IN HGB WITHIN ONE MONTH ON RIBAVIRIN, OR HGB IS 12 G/DL OR LESS OR HCT IS 36% OR LOWER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A
COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B
ERDAFITINIB (BALVERSA)

MEDICATION(S)
BALVERSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
BLADDER CANCER (UROTHELIAL CARCINOMA) THAT HAS SPREAD OR CANNOT BE REMOVED BY SURGERY AND HAS A CHANGE IN THE FGFR GENE KNOWN AS FGFR3 OR FGFR2 AND A PLATINUM CONTAINING TREATMENT DID NOT WORK OR IS NO LONGER WORKING.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ERENUMAB-AOOE (AIMOVIG)

**MEDICATION(S)**
AIMOVIG AUTOINJECTOR

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used with botulinum toxin drugs (e.g. Botox, Dysport, Myobloc, Xeomin) or another CGRP antagonist.

**REQUIRED MEDICAL INFORMATION**
Migraine headache prevention: documentation of 4 or more headache days per month, treatment failure or side effects with at least 2 preventive therapies from the following drug classes: beta blockers, antidepressants, anticonvulsants or there is a medical reason why the patient cannot use the AAN level A or B guideline endorsed preventive drugs.

**AGE RESTRICTION**
18 years of age or older

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

**OTHER CRITERIA**
N/A
ERGOLOID MESYLATES (ERGOLOID MESYLATES)

MEDICATION(S)
ERGOLOID MESYLATES

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
KNOWN HYPERSENSITIVITY TO THIS DRUG OR HAS PSYCHOSIS, ACUTE OR CHRONIC, REGARDLESS OF ETIOLOGY

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
RE-AUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF POSITIVE RESPONSE TO THERAPY
ERLOTNIB (TARCEVA)

MEDICATION(S)
ERLOTINIB HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ESKETAMINE HCL (SPRAVATO)

MEDICATION(S)
SPRAVATO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TREATMENT RESISTANT DEPRESSION: REQUIRES TRIAL AND FAILURE OF 2 DIFFERENT ANTIDEPRESSANTS OF AT LEAST TWO DIFFERENT CLASSES. MUST BE ADMINISTERED BY REMS-CERTIFIED HEALTHCARE PROFESSIONAL

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
PSYCHIATRIST (REMS-CERTIFIED)

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
ESLICARB AZEPINE ACETATE (APTIOM)

MEDICATION(S)
APTIOM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED TRIAL AND FAILURE IN THE LAST 6 MONTHS OR CONTRAINDICATION FOR THE USE OF 2 FORMULARY ALTERNATIVES: LAMOTRIGINE, GABAPENTIN, LEVETIRACETAM, OXCARBAZEPINE, TOPIRAMATE, CARBAMAZEPINE, ZONISAMIDE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ESTROGEN PRODUCTS (HIGH RISK MEDICATION)

MEDICATION(S)
ESTRADIOL 0.0375 MG/DAY PATCH, ESTRADIOL 0.06 MG/DAY PATCH, ESTRADIOL 0.075 MG/DAY PATCH, ESTRADIOL 0.5 MG TABLET, ESTRADIOL 1 MG TABLET, ESTRADIOL 2 MG TABLET, ESTRADIOL TDS 0.025 MG/DAY, ESTRADIOL TDS 0.0375 MG/DAY, ESTRADIOL TDS 0.05 MG/DAY, ESTRADIOL TDS 0.06 MG/DAY, ESTRADIOL TDS 0.075 MG/DAY, ESTRADIOL TDS 0.1 MG/DAY, ESTROPIPATE, MENEST 0.3 MG TABLET, MENEST 0.625 MG TABLET, MENEST 1.25 MG TABLET, PREMARIN 0.3 MG TABLET, PREMARIN 0.45 MG TABLET, PREMARIN 0.625 MG TABLET, PREMARIN 0.9 MG TABLET, PREMARIN 1.25 MG TABLET, PREMPhASE, PREMpro

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Due to increased risk for geriatric population, for ages 65 and older only: documentation that member was evaluated and found to be low risk for: Stroke, DVT, MI, dementia, endometrial and breast cancer.

AGE RESTRICTION
65 years and older.
No prior authorization required for less than 65 years old.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
ETANERCEPT (ENBREL)

MEDICATION(S)
ENBREL, ENBREL SURECLICK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER TARGETED IMMUNOTHERAPY DRUG.

REQUIRED MEDICAL INFORMATION
SPONDYLOARTHRITIS (SPA): PATIENT IS NOT ABLE TO USE NSAIDS DUE TO HISTORY OF GI BLEED OR ULCER OR PATIENT HAS TRIED ONE RX STRENGTH NSAID IN COMBINATION WITH A PPI AND HAD GI SIDE EFFECTS OR PATIENT’S CONDITION DID NOT RESPOND TO A TRIAL OF TWO DIFFERENT RX STRENGTH NSAIDS. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PATIENT HAS TRIED ONE DMARD OR HAS A MEDICAL REASON WHY METHOTREXATE (MTX) CANNOT BE USED. PLAQUE PSORIASIS (PSO), INITIAL USE: PATIENT HAS TRIED ONE DMARD OR HAS A MEDICAL REASON WHY MTX, CYCLOSPORINE, AND ACITRETIN CANNOT BE USED AND BASELINE PASI SCORE 10 OR MORE OR BSA 3% OR MORE OR SENSITIVE AREAS ARE INVOLVED OR DISEASE AFFECTS DAILY LIVING. PSO, ONGOING USE: PASI OR BSA IMPROVED ON ENBREL. PSORIATIC ARTHRITIS (PSA): PATIENT HAS TRIED ONE DMARD OR HAS A MEDICAL REASON WHY MTX, LEFLUNOMIDE, AND SULFASALAZINE CANNOT BE USED. RHEUMATOID ARTHRITIS (RA): PATIENT HAS TRIED ONE DMARD OR HAS MEDICAL REASON WHY MTX, HYDROXYCHLOROQUINE, AND SULFASALAZINE CANNOT BE USED. HIDRADENITIS SUPPRATIVA (HS): HURLEY STAGE II OR III HS AND FAILED OR HAS A MEDICAL REASON NOT TO USE HUMIRA.

AGE RESTRICTION
PSO: 4 YEARS OF AGE OR OLDER. PJIA: 2 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
RA, PJIA, PSA AND AS: RHEUMATOLOGIST PSO: DERMATOLOGIST OR RHEUMATOLOGIST HS: DERMATOLOGIST
COVERAGE DURATION
PSO, INITIAL: 16 WEEKS, ONGOING USE: 12 MONTHS ALL OTHER INDICATIONS: 12 MONTHS

OTHER CRITERIA
N/A
EVEROLIMUS  (AFINITOR DISPERZ)

MEDICATION(S)
AFINITOR DISPERZ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
EVEROLIMUS (AFINITOR)

**MEDICATION(S)**
AFINITOR 10 MG TABLET, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
ADVANCED KIDNEY CANCER: CANCER DID NOT GET BETTER WITH SUTENT OR NEXAVAR.
ADVANCED HORMONE RECEPTOR-POSITIVE, HER2-NEGATIVE BREAST CANCER: CANCER DID NOT GET BETTER WITH TAMOXIFEN OR PRIOR AROMATASE INHIBITOR (E.G. LETROZOLE) TAMOXIFEN, FULVESTRANT, OR AND BEING USED WITH AN AROMATASE INHIBITOR LIKE EXEMESTANE.
BONE CANCER (OSTEOSARCOMA): DISEASE HAS SPREAD TO OTHER AREAS (METASTATIC) OR DISEASE HAS PROGRESSED ON PRIOR CANCER DRUG THERAPY THAT TREATS THE BONE CANCER.
ENDOMETRIAL CANCER (UTERINE CANCER): BEING USED WITH LETROZOLE FOR CANCER THAT HAS REOCCURRED OR SPREAD TO OTHER AREAS.
GASTROINTESTINAL STROMAL TUMORS (GIST): BEING USED WITH IMATINIB, SUNITINIB, OR REGORAFENIB AFTER DISEASE PROGRESSED ON SINGLE AGENT THERAPY WITH IMATINIB, SUNITINIB, OR REGORAFENIB.
CLASSIC HODGKIN LYMPHOMA (CHL): BEING USED AS A SINGLE AGENT FOR THIRD-LINE OR SUBSEQUENT CANCER DRUG THERAPY FOR DISEASE THAT HAS RELAPSED OR DID NOT RESPOND TO PRIOR CANCER DRUG THERAPY.
PERIVASCULAR EPITHELIOID CELL TUMOR (PECOMA), RECURRENT ANGIOMYOLIPOMA, AND LYMPHANGIOLEIOMYOMATOSIS: BEING USED AS A SINGLE AGENT.

**AGE RESTRICTION**
N/A
PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
EVEROLIMUS (ZORTRESS)

MEDICATION(S)
EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, ZORTRESS 1 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRIAL OF OR MEDICAL REASON FOR NOT USING MYCOPHENOLATE AND TACROLIMUS.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
EVOLOCUMAB  (REPATHA)

MEDICATION(S)
REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER PCSK9 DRUG (E.G. PRALUENT) OR A LIPOPOTROPIC DRUG (E.G. JUXTAPID).

REQUIRED MEDICAL INFORMATION
PRIMARY HYPERLIPIDEMIA [INCLUDING HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) OR REDUCTION OF DEATH DUE TO CARDIOVASCULAR DISEASE (CVD)]: CURRENT LDL CHOLESTEROL (LDL-C) IS AT OR ABOVE 70MG/DL (OR AT OR ABOVE 55MG/DL IF PRESCRIBER STATES EXTREME RISK FOR HEART DISEASE) ON LIPID LOWERING THERAPY (SUCH AS STATINS AND/OR EZETIMIBE), AND BEING USED WITH A HIGH-INTENSITY STATIN LIKE ATORVASTATIN 40-80MG OR ROSUVASTATIN 20-40MG UNLESS PATIENT CANNOT USE STATINS DUE TO A MEDICAL REASON (CONTRAINDICATION) OR IS INTOLERANT TO STATINS AS DEFINED BY STATIN RELATED RHABDOMYOLYSIS OR HAS HAD SKELETAL-RELATED MUSCLE SYMPTOMS WITH THE USE OF TWO DIFFERENT STATINS.
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): A POSITIVE GENETIC TEST FOR LDL-R GENETIC MUTATIONS OR CLINICAL EVIDENCE THAT CONFIRMS HOFH, CURRENT LIPID-LOWERING REGIMEN HAS NOT WORKED WELL ENOUGH AND BEING USED WITH OTHER LIPID LOWERING THERAPIES (E.G. STATINS, EZETIMIBE, LDL APHERESIS).

AGE RESTRICTION
HYPERLIPIDEMIA: 18 YEARS OF AGE OR OLDER.
HOFH: 13 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
HOFH: CARDIOLOGIST OR ENDOCRINOLOGIST

COVERAGE DURATION
12 MONTHS
OTHER CRITERIA
N/A
MEDICATION(S)
INREBIC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Not being used with Jakafi.

REQUIRED MEDICAL INFORMATION
Myelofibrosis: platelet count of at least 50,000 cells/mcl, trial and failure of Jakafi or has a medical reason for not using Jakafi (contraindication).

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
MEDICATION(S)
FELBAMATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
HEPATIC DYSFUNCTION

REQUIRED MEDICAL INFORMATION
TREATMENT OF PARTIAL SEIZURE IN ADULTS AND AS ADJUNCTIVE TREATMENT FOR PARTIAL
AND LENNOX GASTAUT SYNDROME IN CHILDREN

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
FENTANYL CITRATE (FENTANYL CITRATE)

MEDICATION(S)
FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 600 MCG, FENTANYL CITRATE OTFC 800 MCG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF PAIN DUE TO CANCER AND DOCUMENTATION OF OPIOID TOLERANCE. PATIENT HAS REMAINED ON AROUND THE CLOCK OPIOID WHILE ON THERAPY

AGE RESTRICTION
NOT APPROVED IF LESS THAN 16 YEARS OF AGE

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PATIENT HAS REMAIN ON AROUND THE CLOCK OPIOID WHILE ON THERAPY
FENTANYL CITRATE NASAL (LAZANDA)

**MEDICATION(S)**
LAZANDA 100 MCG NASAL SPRAY, LAZANDA 300 MCG NASAL SPRAY

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTATION OF PAIN DUE TO CANCER.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
ONCOLOGIST OR PAIN MANAGEMENT SPECIALIST

**COVERAGE DURATION**
6 MONTHS

**OTHER CRITERIA**
N/A
FILGRASTIM (NEUPOGEN, ZARXIO)

MEDICATION(S)
NEUPOGEN, ZARXIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Agranulocytosis, congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia: neutropenia is recurring or does not go away and there is a history of recurring infections (e.g. multiple episodes of infections requiring antibiotics) or at least one hospitalization for an infection within the past year. Febrile neutropenia, neutropenia due to HIV/AIDS, or neutropenia caused by drugs other than cancer drugs: no use of pegfilgrastim within the past 14 days and absolute neutrophil count (ANC) is less than 800/mm³ or ANC is less than 1000/mm³ with neutropenia expected to last more than 5 days. Neutropenia due to cancer drug therapy: not being used with pegfilgrastim. Neutropenia due to radiation therapy: not being used with pegfilgrastim. Acute myeloid leukemia (AML): being used to prevent or reduce neutropenia due to use of cancer drug therapy. MDS: ANC is less than 800/mm³ or ANC is less than 1000/mm³ with neutropenia expected to last more than 5 days or being used with epoetin (e.g. Retacrit) to improve symptoms of low red blood cells (anemia).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS
OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B.
FINGOLIMOD HCL (GILENYA)

MEDICATION(S)
GILENYA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH OTHER DISEASE-MODIFYING THERAPIES FOR RELAPSING MULTIPLE SCLEROSIS.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
FLUOROURACIL CREAM (TOLAK)

MEDICATION(S)
TOLAK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE OR CONTRAINDICATION FOR THE USE OF FLUOROURACIL TOPICAL (CREAM OR SOLUTION) AND IMIQUIMOD

AGE RESTRICTION
NOT APPROVED IN PEDIATRIC PATIENTS

PRESCRIBER RESTRICTION
DERMATOLOGIST

COVERAGE DURATION
4 WEEKS

OTHER CRITERIA
N/A
FONDAPARINUX (ARIXTRA)

MEDICATION(S)
FONDAPARINUX SODIUM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
knee surg prophy: 11 days max
hip surg prophy: 32 DAYS max
DVT prophy: 10 days
DVT/PE tx: 26 days max

OTHER CRITERIA
N/A
FOSTMATINIB (TAVALISSE)

MEDICATION(S)
TAVALISSE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER THROMBOPOIETIN RECEPTOR AGONISTS (TPO-RA).

REQUIRED MEDICAL INFORMATION
CHRONIC IMMUNE THROMBOCYTOPENIA (ITP), INITIAL USE: PLATELET COUNT IS LESS THAN 30,000 CELLS/MCL, AND PATIENT HAS TRIED ONE OF THE FOLLOWING TREATMENTS: CORTICOSTEROIDS (E.G. PREDNISONE), IVIG, ANTI-D, AND SPLENECTOMY OR HAS A MEDICAL REASON NOT TO USE (CONTRAINDICATION) CORTICOSTEROIDS, IVIG, AND ANTI-D. ONGOING USE: PATIENT’S PLATELET COUNT HAS INCREASED FROM BASELINE.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
### GEFITINIB (IRESSA)

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MEDICATION(S)
XOSPATA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
GLASDEGIB MALEATE (DAURISMO)

MEDICATION(S)
DAURISMO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
GLATIRAMER (COPAXONE)

**MEDICATION(S)**
GLATIRAMER ACETATE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
BEING USED WITH OTHER DISEASE-MODIFYING THERAPIES FOR RELAPSING MULTIPLE SCLEROSIS.

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
GLECAPREVIR/PIBRENTASVIR (MAVYRET)

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF THE PATIENT HAS SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C) OR IF CONCURRENT ATAZANAVIR OR RIFAMPIN THERAPY

REQUIRED MEDICAL INFORMATION
DX OF HEP C, HCV RNA DETECTABLE IN SERUM, STATUS OF LIVER DISEASE (ACTIVE, COMPENSATED OR DECOMPENSATED). LABS REQUIRED: CURRENT (LESS THAN 3 MONTHS) VIRAL LOAD, GENOTYPE, LFT. IF PATIENT IS NOT TREATMENT NAIVE: PREVIOUS HCV TREATMENT(S) TRIED AND FAILED

AGE RESTRICTION
NOT APPROVED IF LESS THAN 12 YEARS OF AGE

PRESCRIBER RESTRICTION
HEPATOLOGIST, GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
DURATION OF THERAPY WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE

OTHER CRITERIA
N/A
HIGH RISK MEDICATION

MEDICATION(S)
AMITRIPTYLNE HCL, BENZTROPINE MES 0.5 MG TAB, BENZTROPINE MES 1 MG TABLET, BENZTROPINE MES 2 MG TABLET, BUTALB-CAFF-ACETAMINOPH-CODEIN, CARISOPRODOL, CHLORZOXAZONE 500 MG TABLET, CLEMASTINE FUMARATE, CLOMIPRAMINE HCL, CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, CYPROHEPTADINE 4 MG TABLET, DIPYRIDAMOLE 25 MG TABLET, DIPYRIDAMOLE 50 MG TABLET, DIPYRIDAMOLE 75 MG TABLET, DISOPYRAMIDE PHOSPHATE, DOXEPIN 10 MG CAPSULE, DOXEPIN 10 MG/ML ORAL CONC, DOXEPIN 100 MG CAPSULE, DOXEPIN 150 MG CAPSULE, DOXEPIN 25 MG CAPSULE, DOXEPIN 50 MG CAPSULE, DOXEPIN 75 MG CAPSULE, HYDROXYZINE 10 MG/5 ML SYRUP, HYDROXYZINE 50 MG/25 ML SYRUP, HYDROXYZINE HCL 10 MG TABLET, HYDROXYZINE HCL 25 MG TABLET, HYDROXYZINE HCL 50 MG TABLET, IMIPRAMINE HCL, IMIPRAMINE PAMOATE, INDOMETHACIN 25 MG CAPSULE, INDOMETHACIN 50 MG CAPSULE, INDOMETHACIN ER, KETOROLAC 10 MG TABLET, MEPERIDINE 100 MG TABLET, MEPERIDINE 50 MG TABLET, MEPERIDINE 50 MG/5 ML SOLUTION, MEPHOBAMATE, METHOCARBAMOL 500 MG TABLET, METHOCARBAMOL 750 MG TABLET, METHYLDOPA, METHYLDOPA-HYDROCHLOROTHIAZIDE, PERPHENAZINE-AMITRIPTYLINE, PHENADOZ 12.5 MG SUPPOSITORY, PHENOBARBITAL, PROMETHAZINE 12.5 MG SUPPOS, PROMETHAZINE 12.5 MG TABLET, PROMETHAZINE 25 MG CAPSULE, PROMETHAZINE 25 MG/ML SYRUP, PROMETHAZINE 50 MG SUPPOSITORY, PROMETHAZINE 50 MG TABLET, PROMETHAZINE 50 MG/ML SYRUP, PROMETHEGAN 25 MG SUPPOSITORY, PROMETHEGAN 50 MG SUPPOSITORY, SCOPOLAMINE, THIORIDAZINE HCL, TRIHEXYPHENIDYL HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects.
AGE RESTRICTION
65 years and older.
No prior authorization required for less than 65 years old.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
IBRUTINIB (IMBRUVICA)

MEDICATION(S)
IMBRUVICA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MARGINAL ZONE LYMPHOMA (MZL): PATIENT HAS TRIED AT LEAST ONE PRIOR ANTI-CD20-BASED THERAPY (E.G. RITUXAN, GAZYVA), AND BEING USED AS A SINGLE AGENT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ICATIBANT (FIRAZYR)

MEDICATION(S)
ICATIBANT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
IMMUNOLOGIST, ALLERGIST, HEMATOLOGIST, OR EMERGENCY DEPARTMENT PROVIDER

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B
IDEALISIB (ZYDELIG)

MEDIATION(S)
ZYDELIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)/SMALL LYMPHOCYTIC LYMPHOMA (SLL): CANCER DID NOT RESPOND OR CAME BACK AFTER BEING TREATED WITH AT LEAST ONE PRIOR CHEMOTHERAPY REGIMEN FOR CLL/SLL.
FOLLICULAR B-CELL NON-HODGKIN LYMPHOMA (FNHL): CANCER CAME BACK AFTER BEING TREATED WITH AT LEAST ONE PRIOR CHEMOTHERAPY REGIMEN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
ILOPERIDONE (FANAPT)

MEDICATION(S)
FANAPT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF: 1. ARRHYTHMIA OR 2. CURRENTLY USING MEDICATIONS THAT PROLONG QT INTERVALS (SUCH AS QUINIDINE, AMIODARONE OR METHADONE) OR 3. FOR ELDERLY PATIENTS WITH DEMENTIA RELATED PSYCHOSIS

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE ON A FORMULARY ATYPICAL ANTIPSYCHOTIC SUCH AS: RISPERIDONE, ZIPRASIDONE, QUETIAPINE, OLANZAPINE.

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
IMATINIB MESYLATE (GLEEVEC)

MEDICATION(S)
IMATINIB MESYLATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER TYROSINE KINASE INHIBITOR (E.G. TASIGNA, SPRYCEL, BOSULIF). TENOSYNOVIAL GIANT CELL TUMOR (TGCT): NOT BEING USED WITH TURALIO (PEXIDARTINIB)

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
TGCT: 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
TGCT: ORTHOPEDIC SURGEON OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
IMIQUIMOD (ZYCLARA)

**MEDICATION(S)**
IMIQUIMOD 3.75% CREAM PUMP, ZYCLARA 2.5% CREAM PUMP

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
FOR THE DX OF ACTINIC KERATOSIS, TRIAL AND FAILURE OR CONTRAINDICATION FOR THE USE OF 5-FU AND IMIQUIMOD 5%. FOR THE DX OF CONDYLOMA ACUMINATA TRIAL AND FAILURE OR CONTRAINDICATION FOR THE USE OF IMIQUIMOD 5%.

**AGE RESTRICTION**
FOR DX OF ACTINIC KERATOSIS, NOT APPROVED IF LESS THAN 18 YEARS OF AGE. FOR CONDYLOMA ACUMINATA, NOT APPROVED IF LESS THAN 12 YEARS OF AGE

**PRESCRIBER RESTRICTION**
DERMATOLOGIST OR GYNECOLOGIST

**COVERAGE DURATION**
2 MONTHS

**OTHER CRITERIA**
N/A
IMMUNE GLOBULIN, GAMMA(IGG)/GLYCINE/IGA (GAMUNEX-C)

MEDICATION(S)
GAMUNEX-C 1 GRAM/10 ML VIAL, GAMUNEX-C 10 GRAM/100 ML VIAL, GAMUNEX-C 2.5 GRAM/25 ML VIAL, GAMUNEX-C 20 GRAM/200 ML VIAL, GAMUNEX-C 5 GRAM/50 ML VIAL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A
REQUIRED MEDICAL INFORMATION

PRIMARY IMMUNODEFICIENCY DISORDER (PIDD), SQ AND IV ADMINISTRATION: CURRENT IGG IS LESS THAN 200MG/DL OR ALL OF THE FOLLOWING: PATIENT HAS HISTORY OF RECURRENT BACTERIAL INFECTIONS, AND DOES NOT RESPOND WITH IGG ANTIBODY PRODUCTION AFTER ANTIGENIC CHALLENGE TEST WITH DIPHTHERIA AND TETANUS TOXOIDS OR PNEUMOCOCCAL POLYSACCHARIDE VACCINE, AND HISTORY OF IGG LESS THAN 500MG/DL OR BELOW NORMAL AS DEFINED BY THE LAB TEST DOCUMENTED ON TWO OCCASIONS OR DIAGNOSED BY AN ALLERGIST OR IMMUNOLOGIST IF IGG IS MORE THAN 500MG/DL OR NORMAL AS DEFINED BY THE LAB TEST. CHRONIC INFLAMMATORY Demyelinating polyneuropathy (CIDP), Multifocal acquired demyelinating polyneuropathy, or pure sensory chronic inflammatory demyelinating polyneuropathy (CIDP): IV ADMINISTRATION, DIAGNOSIS CONFIRMED BY ELECTRODIAGNOSTIC CRITERIA AND TWO OF THE FOLLOWING CRITERIA: MOTOR OR SENSORY DYSFUNCTION IN MORE THAN ONE LIMB LASTING AT LEAST 2 MONTHS, NO REFLEXES (ARFLEXIA), NERVE BIOPSY SHOWS EVIDENCE OF DEMYELINATION AND REMYELINATION, OR CSF CELL COUNT IS LESS THAN 10CELLS/MM3 (IF HIV POSITIVE THEN CSF COUNT LESS THAN 50CELLS/MM-3). PRIMARY IMMUNE THROMBOCYTOPENIA (ITP): IV ADMINISTRATION, PLATELET COUNT IS LESS THAN 30,000CELLS/MM3. FOR ONGOING USE: PATIENT HAS HAD A RESPONSE TO IVIG, AND PATIENT HAS CONTINUED THROMBOCYTOPENIA OR IS SCHEDULED FOR SURGERY OR INVASIVE PROCEDURE. MYASTHENIA GRAVIS (MG): IV ADMINISTRATION, PATIENT IS IN ACUTE MYASTHENIC CRISIS WITH DECOMPENSATION AND TREATMENT FAILURE, SIDE EFFECT, OR MEDICAL REASON FOR NOT USING ONE OF THE FOLLOWING: A CORTICOSTEROID, MYCOPHENOLATE, AZATHIOPRINE, CYCLOSPORINE, OR CYCLOPHOSPHAMIDE. MULTIFOCAL MOTOR NEUROPATHY (MMN): IV ADMINISTRATION AND CONDITION CONFIRMED WITH NERVE CONDUCTION STUDIES (ELECTRODIAGNOSTIC TESTING).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIDP, MMN, MG: NEUROLOGIST

COVERAGE DURATION
MG: 3 MONTHS ITP: 6 MONTHS GBS: 5 DAYS ALL OTHER CONDITIONS: PLAN YEAR

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OTHER CRITERIA
AMBD (PEMPHIGUS, EPIDERMOLYSIS BULLOSA ACQUISITA): IV ADMINISTRATION, CONDITION IS CONFIRMED BY TESTING THE SORE OR BLISTER (LESIONAL TISSUE BIOPSY OR SEROLOGY) AND DID NOT RESPOND TO TRIAL OF AN IMMUNOSUPPRESSANT DRUG (E.G. AZATHIOPRINE, CYCLOPHOSPHAMIDE)
INGENOL MEBUTATE (PICATO)

**MEDICATION(S)**
PICATO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
TRIAL AND FAILURE OR CONTRAINDICATION FOR THE USE OF 2 OF THE FOLLOWING ALTERNATIVE THERAPIES: FLUOROURACIL TOPICAL, DICLOFENAC (SOLARAZE), IMIQUIMOD

**AGE RESTRICTION**
NOT COVERED IF LESS THAN 18 YEARS OF AGE

**PRESCRIBER RESTRICTION**
DERMATOLOGIST OR ONCOLOGIST

**COVERAGE DURATION**
3 DAYS

**OTHER CRITERIA**
N/A
INOTUZUMAB OZOGAMICIN (BESPONSA)

**MEDICATION(S)**
BESPONSA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
BEING USED AS PART OF A MULTI-AGENT CANCER DRUG REGIMEN.

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
EXCLUDED UNDER PART D IF COVERED BY PART B.
INTERFERON ALFA-2B (INTRON A)

MEDICATION(S)
INTRON A

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
POLYCYTHEMIA VERA (PV), ESSENTIAL THROMBOCYTHEMIA/THROMBOCYTOSIS: PATIENT HAS TRIED HYDROXYUREA.
MELANOMA (SKIN CANCER): SINGLE AGENT USE FOR STAGE 2 OR 3 DISEASE AFTER SURGERY TO REMOVE THE CANCER.
GIANT CELL TUMOR OF BONE: LOCAL DISEASE AND USED WITH DENOSUMAB OR RADIATION OR SINGLE AGENT USE FOR DISEASE THAT HAS SPREAD TO OTHER AREAS (METASTATIC).

AGE RESTRICTION
INDICATIONS OTHER THAN CHRONIC HEPATITIS B AND CHRONIC HEPATITIS C: 18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
MELANOMA: 12 MONTHS
CARCINOID SYNDROME: 3 MONTHS
ALL OTHER CONDITIONS: 6 MONTHS

OTHER CRITERIA
N/A
INTERFERON BETA-1A (AVONEX, REBIF, BETASERON, EXTAVIA)

MEDICATION(S)
AVONEX, AVONEX PEN, BETASERON, EXTAVIA, REBIF, REBIF REBIDOSE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH OTHER DISEASE-MODIFYING THERAPIES FOR RELAPSING MULTIPLE SCLEROSIS.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
INTERFERON GAMMA-1B (ACTIMMUNE)

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
INTRAVENOUS IMMUNE GLOBULIN (IVIG)

**MEDICATION(S)**
BIVIGAM, CARIMUNE NF NANOFILTERED, GAMMAGARD LIQUID, GAMMAGARD S-D

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP), MULTIFOCAL ACQUIRED DEMYELINATING POLYNEUROPATHY, OR PURE SENSORY CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP): DIAGNOSIS CONFIRMED BY ELECTRODIAGNOSTIC CRITERIA AND TWO OF THE FOLLOWING CRITERIA: MOTOR OR SENSORY DYSFUNCTION IN MORE THAN ONE LIMB LASTING AT LEAST 2 MONTHS, NO REFLEXES (ARFLEXIA), NERVE BIOPSY SHOWS EVIDENCE OF DEMYELINATION AND REMYELINATION, OR CSF CELL COUNT IS LESS THAN 10CELLS/MM3 (IF HIV POSITIVE THEN CSF COUNT LESS THAN 50CELLS/MM-3). PRIMARY IMMUNE THROMBOCYTOPENIA (ITP): PLATELET COUNT IS LESS THAN 30,000CELLS/MM3. FOR ONGOING USE: PATIENT HAS HAD A RESPONSE TO IVIG, AND PATIENT HAS CONTINUED THROMBOCYTOPENIA OR IS SCHEDULED FOR SURGERY OR INVASIVE PROCEDURE. MYASTHENIA GRAVIS (MG): PATIENT IS IN ACUTE MYASTHENIC CRISIS WITH DECOMPENSATION AND TREATMENT FAILURE, SIDE EFFECT, OR MEDICAL REASON FOR NOT USING ONE OF THE FOLLOWING: A CORTICOSTEROID, MYCOPHENOLATE, AZATHIOPRINE, CYCLOSPORINE, OR CYCLOPHOSPHAMIDE. PRIMARY IMMUNODEFICIENCY DISORDER (PIDD): CURRENT IGG IS LESS THAN 200MG/DL OR ALL OF THE FOLLOWING: PATIENT HAS HISTORY OF RECURRENT BACTERIAL INFECTIONS, AND DOES NOT RESPOND WITH IGG ANTIBODY PRODUCTION AFTER ANTIGENIC CHALLENGE TEST WITH DIPHTHERIA AND TETANUS TOXOIDS OR PNEUMOCOCCAL POLYSACCHARIDE VACCINE, AND HISTORY OF IGG LESS THAN 500MG/DL OR BELOW NORMAL AS DEFINED BY THE LAB TEST DOCUMENTED ON TWO OCCASIONS OR DIAGNOSED BY AN ALLERGIST OR IMMUNOLOGIST IF IGG IS MORE THAN 500MG/DL OR NORMAL AS DEFINED BY THE LAB TEST. MULTIFOCAL MOTOR NEUROPATHY (MMN): CONDITION CONFIRMED BY NERVE CONDUCTION STUDIES (ELECTRODIAGNOSTIC TESTING)
AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CIDP, MMN, MG: NEUROLOGIST

COVERAGE DURATION
MG: 3 MONTHS ITP: 6 MONTHS GBS: 5 DAYS ALL OTHER CONDITIONS: PLAN YEAR

OTHER CRITERIA
AMBD (PEMPHIGUS, EPIDERMOLYSIS BULLOSA ACQUISITA): CONDITION IS CONFIRMED BY TESTING THE SORE OR BLISTER (LESIONAL TISSUE BIOPSY OR SEROLOGY) AND DID NOT RESPOND TO TRIAL OF AN IMMUNOSUPPRESSANT DRUG (E.G. AZATHIOPRINE, CYCLOPHOSPHAMIDE) AND AN ORAL OR IV
IPILIMUMAB (YERVOY)

MEDICATION(S)
YERVOY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN) GUIDELINES AND FDA LABELING.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH FDA LABELING AND CURRENT NCCN GUIDELINES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON FDA LABELING AND CURRENT NCCN GUIDELINES.

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
IRINOTECAN LIPOSOMAL (ONIVYDE)

MEDICATION(S)
ONIVYDE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PREScriber RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
ITRACONAZOLE (SPORANOX)

MEDICATION(S)
ITRACONAZOLE 100 MG CAPSULE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
BLASTOMYCOSIS, HISTOPLASMOSIS, SPOROTRICHOSIS, OR ASPERGILLOSIS INFECTION: CULTURE CONFIRMS INFECTION.
TINEA CAPITAS: PATIENT HAS TRIED OR HAS A MEDICAL REASON FOR NOT USING ORAL TERBINAFINE
TINEA CORPORUS, CURIS, PEDIS OR MANUUM: PATIENT HAS TRIED OR HAS A MEDICAL REASON FOR NOT USING TOPICAL ANTIFUNGAL, ORAL TERBINAFINE, OR ORAL FLUCONAZOLE,
TINEA VERSICOLOR: PATIENT HAS TRIED OR HAS A MEDICAL REASON FOR NOT USING TOPICAL KETOCONAZOLE OR ORAL FLUCONAZOLE.
ONYCHOMYCOSIS: PATIENT HAS TRIED OR HAS A MEDICAL REASON FOR NOT USING ORAL TERBINAFINE.
ALLERGIC BRONCHOPULMONARY ASPERGILLOSIS (ABPA): ITRACONAZOLE IS BEING USED TO TAPER ORAL CORTICOSTEROIDS.
CANDIDIASIS, CRYPTOCOCCOSIS, OR COCCIDIOIDOMYCOSIS PREVENTION: PATIENT IS IMMUNOSUPPRESSED/COMPROMISED, AND PATIENT HAS TRIED OR HAS A MEDICAL REASON FOR NOT USING FLUCONAZOLE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A
COVERAGE DURATION
Tinea versicolor: 1 wk
Tinea capitis: 1 mo
Onychomycosis: 3 mo
All other tinea: 2 wk
ABPA: 4 mo
All other dx: 12 months

OTHER CRITERIA
N/A
IVABRADINE (CORLANOR)

MEDICATION(S)
CORLANOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
LEFT HEART VENTRICULAR EJECTION FRACTION (LVEF) LESS THAN OR EQUAL TO 35%, PATIENT IS IN SINUS RHYTHM WITH RESTING HEART RATE OF AT LEAST 70 BEATS PER MINUTE, AND PATIENT IS ON THE HIGHEST TOLERATED DOSE OF GUIDELINE SUPPORTED THERAPIES INCLUDING A RENIN-ANGIOTENSIN INHIBITOR DRUG (E.G. ACE-INHIBITOR, ARB AGENT, ENTRESTO) AND BETA-BLOCKER DRUG (E.G. BISOPROLOL, CARVEDILOL, METOPROLOL SUCCINATE) UNLESS THERE IS A MEDICAL REASON FOR NOT USING (CONTRAINDICATION) THE SUPPORTED THERAPIES. Pediatric patients: CHF is due to dilated cardiomyopathy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CARDIOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
IVACAFTOR (KALYDECO)

MEDICATION(S)
KALYDECO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
TIBSOVO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER DRUG THAT TREATS AML.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
IXAZOMIB CITRATE (NINLARO)

MEDICATION(S)
NINLARO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PREScriber RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
IXEKIZUMAB (TALTZ)

MEDICATION(S)
TALTZ AUTOINJECTOR, TALTZ AUTOINJECTOR (2 PACK), TALTZ AUTOINJECTOR (3 PACK),
TALTZ SYRINGE, TALTZ SYRINGE (2 PACK), TALTZ SYRINGE (3 PACK)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
Spondyloarthritis (SpA): patient is not able to take NSAIDs due to history of GI bleed or ulcer OR patient has tried one RX strength NSAID in combination with a PPI and had GI side effects OR patient’s condition did not respond to a trial of two different RX strength NSAIDs.
Plaque Psoriasis (PsO), initial use: patient has tried one DMARD or has a medical reason why methotrexate (MTX), cyclosporine, and acitretin cannot be used AND baseline PASI score 10 or more OR BSA 3% or more OR sensitive areas are involved OR disease affects daily living. PSO, ongoing use: PASI or BSA improved on Taltz.
Psoriatic Arthritis (PsA): patient has tried one DMARD or has a medical reason why MTX, leflunomide, and sulfasalazine cannot be used.

AGE RESTRICTION
PsO: 6 years of age or older
SpA, PsA: 18 years of age or older.

PRESCRIBER RESTRICTION
PsA: Rheumatologist.
PsO: Rheumatologist or Dermatologist.

COVERAGE DURATION
PsO, initial: 12 weeks - ongoing use: plan year
All other indications: plan year
OTHER CRITERIA
N/A
LACOSAMIDE (VIMPAT)

**MEDICATION(S)**
VIMPAT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTED FAILURE OF 2 FORMULARY FIRST LINE ANTIEPILEPTICS INDICATED FOR PARTIAL ONSET SEIZURE DISORDER: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, TOPIRAMATE, LAMOTRIGINE, LEVETIRACETAM. IF REQUEST IS FOR IV, DOCUMENTATION THAT ORAL ADMINISTRATION IS TEMPORARILY NOT FEASIBLE.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
NEUROLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
LAMIVUDINE SOLUTION (EPIVIR HBV)

MEDICATION(S)
EPIVIR HBV 25 MG/5 ML SOLN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HBSAG POSITIVE FOR LONGER THAN SIX MONTHS, SERUM HBV DNA POSITIVE, PERSISTENT OR INTERMITTENT ELEVATION OF ALT/AST, LIVER BIOPSY SHOWING CHRONIC HEPATITIS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
LANREOTIDE ACETATE (SOMATULINE DEPOT)

MEDICATION(S)
SOMATULINE DEPOT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ONE OF THE FOLLOWING, DIAGNOSIS OF ACROMEGALY WITH LAB RESULTS AND DOCUMENTATION THAT SURGERY AND RADIATION ARE NOT APPROPRIATE FOR PATIENT, DIAGNOSIS OF UNRESECTABLE GASTROENTEROPANCREATIC NEUROENDOCRINE TUMOR, OR DIAGNOSIS OF CARCINOID SYNDROME

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST OR ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR DIAGNOSIS OF ACROMEGALY: TRIAL AND FAILURE OR CONTRAINDICATION TO OCTREOTIDE
**LAPATINIB DITOSYLATE (TYKERB)**

**MEDICATION(S)**
TYKERB

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
COLON AND RECTAL CANCER: PRIOR TREATMENT WITH HER2 INHIBITOR

**REQUIRED MEDICAL INFORMATION**
COLON OR RECTAL CANCER: BEING USED WITH TRASTUZUMAB FOR RAS WILD-TYPE HER2 POSITIVE DISEASE THAT IS NOT ABLE TO BE TREATED WITH SURGERY OR HAS SPREAD TO OTHER AREAS AND PROGRESSED OR DID NOT RESPOND TO PRIOR CANCER DRUG THERAPY (FLUOROPYRIMIDINE-, IRINOTECAN-, OR OXALIPLATIN- BASED THERAPY) OR INTENSIVE THERAPY IS NOT AN OPTION.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
LAROTRECTINIB SULFATE (VITRAKVI)

MEDICATION(S)
VITRAKVI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
HARVONI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT AASLD/IDSA GUIDELINES.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH CURRENT AASLD/IDSA GUIDELINES.

AGE RESTRICTION
3 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
HEPATOLOGIST, GASTROENTEROLOGIST, OR INFECTIOUS DISEASE.

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON CURRENT AASLD/IDSA GUIDELINES AND FDA LABELING.

OTHER CRITERIA
N/A
LENALIDOMIDE (REVLIMID)

MEDICATION(S)
REVLIMID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MDS: TRANSFUSION DEPENDENT OR HEMOGLOBIN LESS THAN 10 G/DL CONFIRMING ANEMIA ASSOCIATED DISEASE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PLAN YEAR

OTHER CRITERIA
N/A
LENVATINIB (LENVIMA)

MEDICATION(S)
LENVIMA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
DIFFERENTIATED THYROID CANCER (DTC) AND HEPATOCellular CARCINOMA (LIVER CANCER): BEING USED AS PART OF A MULTI-AGENT CHEMO REGIMEN.

REQUIRED MEDICAL INFORMATION
MEDULLARY THYROID CANCER: DISEASE PROGRESSED ON CAPRESLA OR COMETRIQ OR THERE IS A MEDICAL REASON WHY THESE AGENTS CANNOT BE USED TO TREAT THE CANCER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
LEVALBUTEROL SOLUTION (XOPENEX)

MEDICATION(S)
LEVALBUTEROL CONCENTRATE, LEVALBUTEROL HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PATIENT HAS HAD A SIDE EFFECT WITH ALBUTEROL NEBULIZED SOLUTION (NOT MDI OR ORAL SYRUP) THAT IS NOT SEEN WITH THE USE OF LEVALBUTEROL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
LEVETIRACETAM (SPRITAM)

MEDICATION(S)
SPRITAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MEDICAL REASON WHY PATIENT IS NOT ABLE TO USE GENERIC LEVETIRACETAM ORAL SOLUTION AND TABLET.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
LEVOMILNACIPRAN HCL (FETZIMA)

MEDICATION(S)
FETZIMA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED TRIED AND FAILURE ON AT LEAST 1 SSRI AND 1 SNRI IN THE LAST 6 MONTHS

AGE RESTRICTION
NOT APPROVED IF PEDIATRIC PATIENT

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
LIDOCAINE (LIDODERM)

**MEDICATION(S)**
LIDOCAINE 5% PATCH

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
LINEZOLID (ZYVOX)

**MEDICATION(S)**
LINEZOLID

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
SKIN OR SOFT TISSUE INFECTION, 14 DAYS OR LESS: CULTURE AND SENSITIVITY RESULTS CONFIRM VRE, MRSA, OR VISA, AND TREATMENT FAILURE, SIDE EFFECT, OR MEDICAL REASON NOT TO USE (CONTRAINDICATION) ONE ORAL DRUG NOTED ON THE CULTURE AND SENSITIVITY REPORT TO WORK ON THE BACTERIA CAUSING THE INFECTION OR PRESCRIBED OR RECOMMENDED BY AN INFECTIOUS DISEASE PHYSICIAN. FOR EMPIRIC THERAPY OF SUSPECTED MRSA INFECTION: PRESCRIBED OR RECOMMENDED BY AN INFECTIOUS DISEASE (ID) SPECIALIST OR PATIENT HAS TRIED ONE ORAL ANTIBIOTIC SUPPORTED FOR MRSA EMPIRIC THERAPY INCLUDING CLINDAMYCIN, DOXYCYCLINE, OR MINOCYCLINE, AND DOUBLE STRENGTH TRIMETHOPRIM/SULFAMETHOXAZOLE, OR CONTRAINDICATION TO ALL ORAL ANTIBIOTICS SUPPORTED FOR MRSA EMPIRIC THERAPY. OSTEOMYELITIS, ENDOCARDITIS, OR OTHER DEEP-SEATED INFECTION: CULTURE AND SENSITIVITY REPORT CONFIRM VRE, MRSA, OR VISA/VRSA AND PRESCRIBED OR RECOMMENDED BY INFECTIOUS DISEASE SPECIALIST. SKIN AND SKIN STRUCTURE INFECTIONS (SSTI) CAUSED BY METHICILLIN-SUSCEPTIBLE STAPHYLOCOCCUS OR STREPTOCOCCUS: RECOMMENDED BY AN INFECTIOUS DISEASE SPECIALIST AND TREATMENT FAILURE, SIDE EFFECT, OR CONTRAINDICATION WITH TWO FORMULARY ORAL DRUGS NOTED ON THE CULTURE AND SENSITIVITY REPORT TO WORK ON THE BACTERIA CAUSING THE INFECTION. MULTIDRUG-RESISTANT TUBERCULOSIS INFECTION (MDR-TB): BEING USED WITH PRETOMANID AND BEDAQUILINE.

**AGE RESTRICTION**
N/A
PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Empiric tx/pneumonia/SSTI: 14 days
VRE: 28 days
Osteo: 42 days
Endocarditis, deep-seated inf.: 56 days

OTHER CRITERIA
COVERAGE DURATION FOR MDR-TB: 26 WEEKS
LORLATINIB (LORBRENA)

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
LUMACAFTOR/IVACAFTOR (ORKAMBI)

MEDICATION(S)
ORKAMBI 100 MG-125 MG TABLET, ORKAMBI 200 MG-125 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF CONCURRENT THERAPY WITH KALYDECO (IVACAFTOR)

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CYSTIC FIBROSIS WITH HOMOZYGOUS F508DEL MUTATION IN THE CFTR GENE, DOCUMENTED IN THE LAB REPORT UTILIZING FDA APPROVED TEST.

AGE RESTRICTION
NOT APPROVED IF LESS THAN 2 YEARS OF AGE

PRESCRIBER RESTRICTION
PULMONOLOGIST

COVERAGE DURATION
28 WEEKS

OTHER CRITERIA
RENEWAL OF THIS DRUG REQUIRES DOCUMENTATION OF ONE OF THE FOLLOWING: MAINTAINED OR IMPROVEMENT IN FEV1 OR BMI OR REDUCTION IN PULMONARY EXACERBATIONS
LUMATEPERONE (CAPLYTA)

**MEDICATION(S)**
CAPLYTA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Trial and failure or side effect with one of the following preferred atypical antipsychotics: aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone OR there is a medical reason for not using the preferred atypical antipsychotics (contraindication).

**AGE RESTRICTION**
18 years of age or older

**PRESCRIBER RESTRICTION**
Psychiatrist

**COVERAGE DURATION**
Plan year

**OTHER CRITERIA**
N/A
LURASIDONE (LATUDA)

MEDICATION(S)
LATUDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PATIENT HAS TRIED ONE PREFERRED ATYPICAL ANTIPSYCHOTIC DRUG SUCH AS ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, OR ZIPRASIDONE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
SCHIZOPHRENIA: PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MECASERMIN (INCRELEX)

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
SEVERE PRIMARY IGF-1 DEFICIENCY: BEING USED WITH GROWTH HORMONE THERAPY.

REQUIRED MEDICAL INFORMATION
INITIAL USE: HEIGHT IS AT OR MORE THAN 3.0 STANDARD DEVIATIONS BELOW STANDARD RANGE FOR SEX AND AGE, AND BASAL IGF-1 IS AT OR MORE THAN 3.0 STANDARD DEVIATIONS BELOW STANDARD RANGE FOR SEX AND AGE, AND EVIDENCE OF DELAYED BONE AGE, AND FOR SEVERE IGF-1 DEFICIENCY GROWTH HORMONE LEVEL IS NORMAL OR HIGHER FOR SEX AND AGE.
ONGOING USE: RESPONSE TO THERAPY CONFIRMED BY AN INCREASE IN GROWTH VELOCITY OF MORE THAN 2 CM IN THE PAST YEAR AND EVIDENCE OF DELAYED BONE AGE.

AGE RESTRICTION
PATIENT IS BETWEEN 2 TO 18 YEARS OF AGE.

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MECHLORETHAMINE (VALCHLOR)

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MERCAPTOPURINE MONOHYDRATE (PURIXAN)

**MEDICATION(S)**
PURIXAN

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
MEDICAL REASON WHY PATIENT CANNOT USE MERCAPTOPURINE TABLET.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
METHOTREXATE ORAL SOLUTION (XATMEP)

MEDICATION(S)
XATMEP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MEDICAL REASON WHY PATIENT CANNOT TAKE TABLET FORM OF METHOTREXATE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
METHYLNALTREXONE (RELISTOR SQ)

**MEDICATION(S)**
RELISTOR 12 MG/0.6 ML SYRINGE, RELISTOR 12 MG/0.6 ML VIAL, RELISTOR 8 MG/0.4 ML SYRINGE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTED CONCOMITANT OPIOID USE, TRIAL AND FAILURE ON LACTULOSE AND PEG 3350

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
METHYLTESTOSTERONE (METHYLTESTOSTERONE)

MEDICATION(S)
METHYLTESTOSTERONE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MORNING TOTAL SERUM TESTOSTERONE LESS THAN 300 NG/DL OR SERUM FREE TESTOSTERONE LESS THAN 50 PG/ML

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
FOR BREAST CANCER DIAGNOSIS: ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
MIDOSTAURIN (RYDAPT)

MEDICATION(S)
RYDAPT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
AML INDUCTION: TWO MONTHS
AML CONSOLIDATION: FOUR MONTHS
MASTOCYTOSIS: 12 MONTHS

OTHER CRITERIA
N/A
MIFEPRISTONE (KORYLYM)

MEDICATION(S)
KORLYM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MIGLUSTAT (ZAVESCA)

MEDICATION(S)
MIGLUSTAT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED IN WITH ANOTHER THERAPY FOR GAUCHERS DISEASE TYPE-1.

REQUIRED MEDICAL INFORMATION
DISEASE CONFIRMED BY EITHER GLUCOCEREBROSIDASE ENZYME ACTIVITY IN THE WHITE BLOOD CELLS OR SKIN FIBROBLASTS LESS OR EQUAL TO 30% OF NORMAL ACTIVITY OR GENETIC ANALYSIS IDENTIFYING TWO COPIES OF A MUTANT GLUCOCEREBROSIDASE ENCODING ALLELE, AND PATIENT HAS AT LEAST ONE OF THE FOLLOWING: LOW RED BLOOD CELL COUNT (ANEMIA) WITH A LOW HEMOGLOBIN FOR AGE AND SEX, LOW PLATELET COUNT (THROMBOCYTOPENIA) WITH A PLATELET COUNT UNDER 100,000 CELLS/MCL OR BLEEDING EPISODES DOCUMENTED AS BEING DUE TO THROMBOCYTOPENIA, EVIDENCE OF BONE DISEASE, ENLARGED LIVER (HEPATOMEGALY), ENLARGED SPLEEN (SPLENOMEGALY), OR CLINICAL SYMPTOMS OF ABDOMINAL PAIN, FATIGUE, IMPAIRED PHYSICAL MOVEMENTS, MALNUTRITION (CACHEXIA), OR BONE PAIN.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MILNACIPRAN (SAVELLA)

MEDICATION(S)
SAVELLA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
NOT INDICATED FOR PEDIATRIC PATIENTS

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
RE-AUTHORIZATIONS WILL REQUIRE DOCUMENTATION OF IMPROVEMENT OF PAIN AND SYMPTOMS
MODAFINIL (PROVIGIL)

MEDICATION(S)
MODAFINIL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
NARCOLEPSY: SLEEP STUDY (POLYSOMNOGRAPHY) CONFIRMS NARCOLEPSY.
OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME (OSAHS): SLEEP STUDY (POLYSOMNOGRAPHY) CONFIRMS OSAHS AND HYPERSOMNOLENCE SCORE OF AT LEAST 10 ON THE EPWORTH SLEEPINESS SCALE.
SHIFT WORK SLEEP DISORDER: PATIENT IS NIGHT SHIFT WORKER WITH HOURS OF 11PM-7AM, EARLY MORNING SHIFT WORKER WITH STARTING HOURS BETWEEN 4AM -7AM, OR ROTATING SHIFT WORKER WITH NIGHT SHIFTS.
REFRACTORY DEPRESSION: PRESCRIBED OR RECOMMENDED BY A PSYCHIATRIST OR PATIENT HAS FAILED ONE PRIOR ANTIDEPRESSANT REGIMEN AND IS EXPERIENCING SYMPTOMS OF FATIGUE OR EXCESSIVE DAYTIME SLEEPINESS WHILE ON THE CURRENT ANTIDEPRESSANT REGIMEN, AND MODAFINIL WILL BE ADDED TO CURRENT REGIMEN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
BIPOLAR DEPRESSION: PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
Poteligio

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH OTHER CANCER DRUG TREATMENTS.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
PATIENT IS AT LEAST 18 YEARS OLD.

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
NERATINIB (NERLYNX)

MEDICATION(S)
NERLYNX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED CONCURRENTLY WITH HERCEPTIN.

REQUIRED MEDICAL INFORMATION
BEING USED AS EXTENDED POST-SURGERY (ADJUVANT) TREATMENT FOR EARLY STAGE (I-IIIC) HER2-POSITIVE BREAST CANCER AFTER HERCEPTIN-BASED THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
NILOTINIB (TASIGNA)

MEDICATION(S)
TASIGNA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CHRONIC MYELOID LEUKEMIA (CML): PATIENT HAS TRIED IMATINIB OR HAS A MEDICAL REASON NOT TO USE IMATINIB FIRST-LINE.
GASTROINTESTINAL STROMAL TUMOR (GIST): PATIENT HAS DISEASE PROGRESSION DESPITE PRIOR IMATINIB, REGORAFENIB (STIVARGA) AND SUNITINIB (SUTENT) THERAPY. ACUTE LYMPHOBLASTIC LEUKEMIA (ALL): PHILADELPHIA CHROMOSOME POSITIVE AND PATIENT HAS A MEDICAL REASON NOT TO USE IMATINIB.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
**NINTEDANIB ESYLATE (OFEV)**

**MEDICATION(S)**
OFEV

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
- BEING USED WITH ANOTHER IPF DRUG.
- BEING USED FOR SEVERE IPF DISEASE WHERE FVC IS UNDER 50% OR DLCO IS UNDER 30%.

**REQUIRED MEDICAL INFORMATION**
IDIOPATHIC PULMONARY FIBROSIS (IPF), INITIAL USE: PATIENT HAS MILD TO MODERATE DISEASE CONFIRMED BY THE FOLLOWING PULMONARY FUNCTION TESTS: FORCED VITAL CAPACITY (FVC) EQUAL OR OVER 50%, AND DIFFUSING CAPACITY OF CARBON MONOXIDE (DLCO) EQUAL OR OVER 30%. ONGOING USE: PATIENT HAS NOT RECEIVED A LUNG TRANSPLANT, PATIENT CONTINUES TO HAVE MILD TO MODERATE IPF DISEASE CONFIRMED BY THE FOLLOWING PULMONARY FUNCTION TESTS: FVC EQUAL OR ABOVE 50% AND DLCO IS EQUAL OR OVER 30%.

SYSTEMIC SCLEROSIS-ASSOCIATED OR CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE: PULMONARY FUNCTION TESTS SHOW FVC EQUAL OR OVER 40% AND DLCO EQUAL OR OVER 30% OF PREDICTED NORMAL.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
PULMONOLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
NIRAPARIB TOSYLATE (ZEJULA)

MEDICATION(S)
ZEJULA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED AS PART OF A MULTI-DRUG CHEMOTHERAPY REGIMEN.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
NITAZOXANIDE (ALINIA)

MEDICATION(S)
ALINIA 500 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
STOOL MICROSCOPY RESULTS CONFIRMING DX.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 DAYS

OTHER CRITERIA
FOR GIARDIA LAMBLIA ONLY: TRIAL AND FAILURE OR CONTRAINDICATION TO METRONIDAZOLE THERAPY
MEDICATION(S)
NITISINONE, ORFADIN 10 MG CAPSULE, ORFADIN 2 MG CAPSULE, ORFADIN 20 MG CAPSULE, ORFADIN 5 MG CAPSULE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PEDIATRIC GASTROENTEROLOGIST OR HEPATOLOGIST OR ENDOCRINOLOGIST OR METABOLIC SPECIALIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
NITROGLYCERIN RECTAL (RECTIV)

MEDICATION(S)
RECTIV

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
NOT APPROVED IN PATIENT UNDER 18 YEARS OLD

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
21 DAYS

OTHER CRITERIA
N/A
MEDICATION(S)
OPDIVO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN) GUIDELINES AND FDA LABELING.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH FDA LABELING AND CURRENT NCCN GUIDELINES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON FDA LABELING AND CURRENT NCCN GUIDELINES.

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
OBINUTUZUMAB (GAZYVA)

MEDICATION(S)
GAZYVA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CLL: 6 MONTHS, FL MAINTENANCE: 2 YEARS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
MEDICATION(S)
ARZERRA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN) GUIDELINES AND FDA LABELING.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH FDA LABELING AND CURRENT NCCN GUIDELINES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON FDA LABELING AND CURRENT NCCN GUIDELINES.

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
OLANZAPINE PAMOATE  (ZYPREXA RELPREVV)

MEDICATION(S)
ZYPREXA RELPREVV

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF DEMENTIA-RELATED PSYCHOSIS IN ELDERLY (65 YEARS OLD AND OLDER) PATIENTS

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF FAILURE OR CONTRAINDICATION TO USE OF ORAL ANTIPSYCHOTIC AGENT AND TRIAL ON RISPERIDONE INJECTABLE. PRESCRIBER, HEALTHCARE FACILITY, PATIENT AND PHARMACY SHOULD BE ENROLLED IN ZYPREXA RELPREVV PATIENT CARE PROGRAM.

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B
OLAPARIB CAPSULE (LYNPARZA)

MEDICATION(S)
LYNPARZA 50 MG CAPSULE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
OLAPARIB TABLET (LYNPARZA)

MEDICATION(S)
LYNPARZA 100 MG TABLET, LYNPARZA 150 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
OLARATUMAB (LARTRUVO)

MEDICATION(S)
LARTRUVO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
OMALIZUMAB (XOLAIR)

MEDICATION(S)
XOLAIR 150 MG VIAL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
ALLERGIC ASTHMA: BEING USED WITH OTHER TARGETED THERAPIES (E.G. NUCALA, CINQAIR, DUPIXENT, FASENRA).
ALLERGIC ASTHMA: BEING USED AS A SINGLE AGENT.

REQUIRED MEDICAL INFORMATION
ALLERGIC ASTHMA, INITIAL USE: RECENT TOTAL SERUM IGE LEVEL IS MORE THAN 30IU/ML, DOCUMENTED TREATMENT FAILURE WITH RECENT USE OF HIGH-DOSE INHALED CORTICOSTEROID ALONG WITH LONG-ACTING BETA AGONIST, AND PATIENT HAS HAD AT LEAST ONE OF THE FOLLOWING WITHIN THE PAST YEAR: ONE OR MORE ACUTE ASTHMA-RELATED ER VISIT(S), ONE OR MORE ACUTE INPATIENT VISITS WHERE ASTHMA WAS THE DIAGNOSIS, OR TWO OR MORE ACUTE ASTHMA EXACERBATIONS THAT REQUIRE ORAL CORTICOSTEROIDS. 1ST REAUTH: IMPROVEMENT IN ASTHMA SYMPTOMS CONFIRMED BY ONE OR MORE OF THE FOLLOWING: FEWER ASTHMA ATTACKS, A DECREASE IN THE DOSE OR HOW OFTEN YOU USE YOUR ORAL OR INHALED STEROIDS, OR A REDUCTION IN YOUR ASTHMA SYMPTOMS (E.G. FEWER SICK DAYS, LESS USE OF A RESCUE INHALER). ONGOING USE: PATIENTS ASTHMA SYMPTOMS ARE STABLE OR EVEN MORE IMPROVED, DAILY DOSE OF INHALED STEROIDS IS STABLE OR REDUCED (NOT DISCONTINUED), OR PATIENT HAS NOT NEEDED ORAL CORTICOSTEROIDS OR HAS LESS NEED THAN BEFORE DUE TO LESS ASTHMA EXACERBATIONS. CHRONIC IDIOPATHIC URTICARIA (CIU): FAILURE TO RESPOND TO HYDROXYZINE, DOXEPIN, OR HIGH DOSE SECOND-GENERATION ANTIHISTAMINES OR HAS A MEDICAL REASON NOT TO USE (CONTRAINDICATION) OR HAD A SIDE EFFECT TO HYDROXYZINE, DOXEPIN, AND SECOND-GENERATION ANTIHISTAMINES.

AGE RESTRICTION
ALLERGIC ASTHMA: 6 YEARS OF AGE OR OLDER. CIU: 12 YEARS OF AGE OR OLDER.
PRESCRIBER RESTRICTION
CIU: ALLERGIST OR IMMUNOLOGIST ALLERGIC ASTHMA: PULMONOLOGIST OR IMMUNOLOGIST

COVERAGE DURATION
ALLERGIC ASTHMA, INITIAL & 1ST REAUTH: 6 MONTHS, ONGOING USE: 12 MONTHS CIU: 12 MONTHS

OTHER CRITERIA
N/A
OSIMERTINIB (TAGRISSO)

MEDICATION(S)
TAGRISSO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
OSPEMIFENE (OSPHENA)

MEDICATION(S)
OSPHENA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PAINFUL SEX (DYSPAREUNIA) DUE TO MENOPAUSE: PATIENT HAS TRIED PREMARIN VAGINAL CREAM.
VAGINAL DRYNESS DUE TO MENOPAUSE: PATIENT HAS TRIED AT LEAST TWO OF THE FOLLOWING: PREMARIN VAGINAL CREAM, ESTRADIOL VAGINAL CREAM, ESTRADIOL VAGINAL TABLET, YUVAFEM, OR ESTRING.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
OXANDROLONE (OXANDRIN)

MEDICATION(S)
OXANDROLONE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
WILL BE USED WITH SEROSTIM OR NANDROLONE.

REQUIRED MEDICAL INFORMATION
AIDS WASTING OR CACHEXIA ASSOCIATED WITH CHRONIC DISEASE, INITIAL USE: PATIENT MEETS ONE OF THE FOLLOWING: WEIGHS LESS THAN 90% IDEAL BODY WEIGHT, OR HAS LOST 10% OR MORE OF USUAL BODY WEIGHT, OR HAS A BASELINE BIA OR TOTAL BODY DEXA SHOWING BODY CELL MASS BELOW 40% IN MALES AND 35% IN FEMALES. ONGOING USE: BODY WEIGHT OR BODY CELL MASS (BCM) HAS IMPROVED OR STABILIZED ON OXANDROLONE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
INITIAL USE: 3 MONTHS
ONGOING USE: 6 MONTHS

OTHER CRITERIA
N/A
OXCARBAZEPINE (OXTELLAR XR)

MEDICATION(S)
OXTELLAR XR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE OF 2 FORMULARY AGENTS INDICATED FOR PARTIAL SEIZURES (SUCH AS LAMOTRIGINE, LEVETIRACETAM, TOPIRAMATE) INCLUDING IMMEDIATE RELEASE OXCARBAZEPINE

AGE RESTRICTION
NOT APPROVED IF LESS THAN 6 YEARS OF AGE

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
MUST BE USED AS ADJUNCTIVE THERAPY
OXYCODONE EXTENDED RELEASE (OXYCONTIN)

MEDICATION(S)
OXYCODONE HCL ER 10 MG TABLET, OXYCODONE HCL ER 15 MG TABLET, OXYCODONE HCL ER 20 MG TABLET, OXYCODONE HCL ER 30 MG TABLET, OXYCODONE HCL ER 40 MG TABLET, OXYCONTIN ER 15 MG TABLET, OXYCONTIN ER 30 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE OR INTOLERANCE TO EXTENDED RELEASE MORPHINE AND FENTANYL PATCHES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
PALBOCICLIB (IBRANCE)

MEDICATION(S)
IBRANCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
SOFT TISSUE SARCOMA: PATIENT HAS A RETROPERITONEAL LIPOSARCOMA EITHER DEFINED AS WELL DIFFERENTIATED (WDLs) OR DEDIFFERENTIATED (DDLS).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
PALIPERIDONE ER (INVEGA)

MEDICATION(S)
PALIPERIDONE ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
OLDER ADULTS (65 YEARS AND OLDER) WITH DEMENTIA-RELATED PSYCHOSIS.

REQUIRED MEDICAL INFORMATION
TRIAL OF RISPERIDONE AND ONE OTHER PREFERRED ATYPICAL ANTIPSYCHOTIC SUCH AS ARIPIPRAZOLE, ZIPRASIDONE, QUETIAPINE, OR OLANZAPINE.

AGE RESTRICTION
SCHIZOPHRENIA: 12 YEARS OF AGE OR OLDER
SCHIZOAFFECTIVE DISORDER: 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
INVEGA SUSTENNA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
OLDER ADULTS (65 YEARS AND OLDER) WITH DEMENTIA-RELATED PSYCHOSIS.

REQUIRED MEDICAL INFORMATION
TREATMENT FAILURE WITH AT LEAST ONE ORAL ATYPICAL ANTIPSYCHOTIC (RISPERIDONE, ZIPRASIDONE, QUETIAPINE, OLANZAPINE, ARIPIPRAZOLE).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
INVEGA TRINZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
OLDER ADULTS (65 YEARS AND OLDER) WITH DEMENTIA-RELATED PSYCHOSIS.

REQUIRED MEDICAL INFORMATION
TREATMENT FAILURE WITH AT LEAST ONE ORAL ATYPICAL ANTIPSYCHOTIC (RISPERIDONE, ZIPRASIDONE, QUETIAPINE, OLANZAPINE, ARIPIPRAZOLE) AND USE OF INVEGA SUSTENNA FOR AT LEAST 4 MONTHS.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
PANOBINOSTAT LACTATE (FARYDAK)

MEDICATION(S)
FARYDAK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT THE PATIENT RECEIVED AND FAILED AT LEAST 2 PRIOR REGIMENS: AN IMMUNOMODULATOR AGENT (SUCH AS THALIDOMIDE OR LENALIDOMIDE) AND BORTEZOMIB.

AGE RESTRICTION
NOT APPROVED FOR PEDIATRIC PATIENTS

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
MAXIMUM OF 16 CYCLES APPROVED
PARATHYROID HORMONE (NATPARA)

**MEDICATION(S)**
NATPARA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTATION AND LAB TESTS CONFIRMING HYPOCALCEMIA IN PATIENTS WITH PARATHYROIDISM WHO HAVE THE FOLLOWING CRITERIA MET: HYPOTHYROIDISM IS NOT DUE TO CALCIUM SENSING RECEPTOR MUTATION OR HYPOTHYROIDISM IS NOT CONSIDERED ACUTE POST SURGICAL.

**AGE RESTRICTION**
NOT APPROVED IF LESS THAN 18 YEARS OLD

**PRESCRIBER RESTRICTION**
ENDOCRINOLOGT

**COVERAGE DURATION**
6 MONTHS

**OTHER CRITERIA**
DOCUMENTATION THAT THE PATIENT IS NOT AT INCREASED RISK FOR OSTEOSARCOMA.
PART B VS PART D

MEDICATION(S)
DOCETAXEL 20 MG/ML VIAL, DOCETAXEL 80 MG/4 ML VIAL, GEMCITABINE 1 GRAM/26.3 ML VL, GEMCITABINE 2 GRAM/52.6 ML VL, GEMCITABINE 200 MG/5.26 ML VL, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 8 MG TABLET

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A
MEDICATION(S)
ABELCET, ACETYLCYSTEINE 20% VIAL, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500
MG/10 ML VIAL, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 5 MG/ML SOLUTION,
ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5
MG/3 ML SOLN, ALIMTA, AMBISOME, AMIFOSTINE, AMINOSYN II 15% IV SOLUTION,
AMINOSYN-HBC, AMINOSYN-PF 7% IV SOLUTION, AMPHOTERICIN B, APREPITANT 125 MG
CAPSULE, APREPITANT 125-80-80 MG PACK, APREPITANT 80 MG CAPSULE, ARSENIC
TRIOXIDE 12 MG/6 ML VL, AVASTIN, AZACITIDINE, AZATHIOPRINE, AZATHIOPRINE SODIUM,
BELEODAQ, BLEOMYCIN SULFATE, BLINCYTO, BORTEZOMIB, BUSULFAN, CALCITRIOL 0.25
MG CAPSULE, CALCITRIOL 0.5 MCG CAPSULE, CEFOXITIN 1 GM VIAL, CEFOXITIN 1 GM
PIGGYBACK BAG, CHLORPROMAZINE 25 MG/ML AMP, CINACALCIT HCL, CLOFARABINE,
CROMOLYN 20 MG/2 ML NEB SOLN, CYCLOPHOSPHAMIDE 25 MG CAPSULE,
CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE, CYCLOSPORINE MODIFIED,
DACTINOMYCIN, DECITABINE, DOCETAXEL, DOXERCALCIFEROL 0.5 MCG CAP,
DOXERCALCIFEROL 1 MCG CAPSULE, DOXERCALCIFEROL 2.5 MCG CAP, DOXY 100, ELITEK,
ENGERIX-B 20 MCG/ML SYRN, ENGERIX-B PEDIATRIC-adoLESCENT, FLUOROURACIL 1,000
MG/20 ML VL, FLUOROURACIL 2,500 MG/50 ML VL, FLUOROURACIL 2.5 GM/50 ML BTL,
FLUOROURACIL 2.5 GM/50 ML VIAL, FLUOROURACIL 5 GM/100 ML BTL, FLUOROURACIL 5
GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, FLUOROURACIL 500 MG/10 ML VIAL,
FLUPHENAZINE DECANOATE, FLUPHENAZINE 2.5 MG/ML VIAL, FOLOTYN, FREMINE HBC,
GEMCITABINE 1 GRAM/26.3 ML VL, GEMCITABINE 2 GRAM/52.6 ML VL, GEMCITABINE 200
MG/5.26 ML VL, GEMCITABINE HCL 1 GRAM VIAL, GEMCITABINE HCL 1 GRAM/10 ML,
GEMCITABINE HCL 2 GRAM VIAL, GEMCITABINE HCL 2 GRAM/20 ML, GEMCITABINE HCL
200 MG VIAL, GEMCITABINE HCL 200 MG/2 ML VL, GENGTAC, GRANISETRON HCL 1 MG
TABLET, HALAVENT, HALOPERIDOL DEC 250 MG/5 ML VL, HALOPERIDOL DEC 50 MG/ML
VIAL, HALOPERIDOL DECAN 50 MG/ML AMP, HALOPERIDOL LAC 5 MG/ML AMPUL,
HALOPERIDOL LAC 5 MG/ML SYRING, HALOPERIDOL LAC 5 MG/ML VIAL, HALOPERIDOL
LAC 50 MG/10 ML VL, HERCEPTIN, INTRALIPID, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-
ALBUTEROL, ISTODAX, JEVITANA, LEUCOVORIN CALCIUM 100 MG VIAL, LEUCOVORIN
CALCIUM 200 MG VIAL, LEUCOVORIN CALCIUM 350 MG VIAL, LEUCOVORIN CALCIUM 50
MG VIAL, LEUCOVORIN CALCIUM 500 MG VL, LEVOLEUCOVORIN CALCIUM, LUMOXITI,
MELPHALAN HCL, MITOXANTRONE HCL, MYCOPHENOLATE 200 MG/ML SUSP,
MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, MYCOPHENOLIC
ACID, MYLOTARG, NEPHRAMINE, NULOJIX, OCTREOTIDE 1,000 MCG/5 ML VIAL,
OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET
0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL,
OCTREOTIDE ACET 200 MCG/ML VIAL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE
ACET 50 MCG/ML VIAL, OCTREOTIDE ACET 500 MCG/ML AMP, OCTREOTIDE ACET 500
MG/ML VL, OLANZAPINE 10 MG VIAL, ONCASPAR, ONDANSETRON 4 MG/5 ML SOLUTION,
ONDANSETRON HCL 24 MG TABLET, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL
8 MG TABLET, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PENTAMIDINE 300 MG INHAL
POWDR, PHENYTOIN SODIUM, PORTRAZZA, PREMASOL, PROGRAF 5 MG/ML AMPUL,
DETAILS
This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
PASIREOTIDE DIASPARTATE (SIGNIFOR)

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CUSHINGS DISEASE, INITIAL USE: PITUITARY SURGERY IS NOT AN OPTION OR HAS NOT BEEN CURATIVE.
ONGOING USE: PATIENT RESPONDED TO INITIAL TREATMENT CONFIRMED BY A DECREASE IN THE MEAN 24-HOUR URINARY FREE CORTISOL (UFC).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
INITIAL: 3 MONTHS
REAUTH: 1 YEAR

OTHER CRITERIA
N/A
PASIREOTIDE PAMOATE (SIGNIFOR LAR)

MEDICATION(S)
SIGNIFOR LAR 10 MG KIT, SIGNIFOR LAR 10 MG VIAL, SIGNIFOR LAR 30 MG KIT, SIGNIFOR LAR 30 MG VIAL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ACROMEGALY. DOCUMENTATION OF TRIAL AND FAILURE OF SOMATULINE DEPOT OR SANDOSTATIN DEPOT LAR

AGE RESTRICTION
NOT APPROVED FOR PEDIATRIC PATIENTS

PRESCRIBER RESTRICTION
ENDOCRINOLOGIST

COVERAGE DURATION
12 WEEKS INITIALLY, 12 MONTHS THEREAFTER

OTHER CRITERIA
N/A
PAZOPANIB HCL (VOTRIENT)

**MEDICATION(S)**
VOTRIENT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
CANCER IS ADIPOCYTIC SOFT TISSUE SARCOMA.

**REQUIRED MEDICAL INFORMATION**
THYROID CANCER, MEDULLARY DISEASE: PATIENT HAS TRIED CAPRELSA OR COMETRIQ
THYROID CANCER, NON-MEDULLARY (FOLLICULAR) DISEASE: PATIENT HAS TRIED
RADIOACTIVE IODINE TREATMENT.
UTERINE SARCOMA: BEING USED AS A SINGLE AGENT TO TREAT CANCER THAT HAS COME
BACK OR SPREAD TO OTHER AREAS (METASTATIC) AND PROGRESSED ON PRIOR CANCER
DRUG (CYTOTOXIC) THERAPY.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
PEGFILGRASTIM (NEULASTA)

MEDICATION(S)
NEULASTA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED CONCURRENTLY WITH FILGRASTIM.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CHEMO-INDUCED: DURATION OF CHEMO
RADIATION-INDUCED: DURATION OF RADIATION

OTHER CRITERIA
N/A
PEGINTERFERON ALFA-2A (PEGASYS)

**MEDICATION(S)**
PEGASYS, PEGASYS PROCLICK 180 MCG/0.5

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
MYELOFIBROSIS,
POLYCYTHEMIA VERA,
ESSENTIAL THROMBOCYTHEMIA,
SYSTEMIC MASTOCYTOSIS

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
CHRONIC HEPATITIS C VIRAL INFECTION: CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
HEPATITIS B: 48 WEEKS
HEPATITIS C: BASED ON AASLD-IDSA GUIDANCE

**OTHER CRITERIA**
N/A
**PEGINTERFERON ALFA-2B (SYLATRON)**

**Medication(s)**
SYLATRON

**PA Indication Indicator**
3 - All Medically-Accepted Indications

**Off Label Uses**
N/A

**Exclusion Criteria**
PATIENT HAS HAD MORE THAN 5 YEARS OF THERAPY.
BEING USED AS PART OF A MULTI-DRUG CHEMOTHERAPY REGIMEN.

**Required Medical Information**
N/A

**Age Restriction**
N/A

**Prescriber Restriction**
N/A

**Coverage Duration**
12 MONTHS

**Other Criteria**
N/A
PEGINTERFERON BETA-1A (PLEGRIDY)

MEDICATION(S)
PLEGRIDY, PLEGRIDY PEN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
PEGVISOMANT (SOMAVERI)

**MEDICATION(S)**
SOMAVERI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTATION OF PREVIOUS TREATMENT FAILURE ON OCTREOTIDE

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
ENDOCRINOLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
PEMBROLIZUMAB (KEYTRUDA)

MEDICATION(S)
KEYTRUDA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN) GUIDELINES AND FDA LABELING.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH FDA LABELING AND CURRENT NCCN GUIDELINES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON FDA LABELING AND CURRENT NCCN GUIDELINES.

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
PEMIGATINIB (PEMAZYRE)

MEDICATION(S)
PEMAZYRE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
MEDICATION(S)
DENAVIR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF ACYCLOVIR FAILURE OR CONTRAINDICATION

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
4 DAYS

OTHER CRITERIA
N/A
PENICILLAMINE (CUPRIMINE)

**MEDICATION(S)**

PENICILLAMINE

**PA INDICATION INDICATOR**

3 - All Medically-Accepted Indications

**OFF LABEL USES**

N/A

**EXCLUSION CRITERIA**

N/A

**REQUIRED MEDICAL INFORMATION**

FOR THE TX OF RA: TRIAL AND FAILURE ON AT LEAST 1 NSAID AND 1 DMARD (MTX OR SULFASALAZINE)

**AGE RESTRICTION**

N/A

**PRESCRIBER RESTRICTION**

RHEUMATOLOGIST, HEPATOLOGIST, UROLOGIST OR NEPHROLOGIST

**COVERAGE DURATION**

6 MONTHS

**OTHER CRITERIA**

N/A
PERAMPANEL (FYCOMPA)

**MEDICATION(S)**
FYCOMPA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
PATIENT MUST HAVE TRIED AND FAILED IN THE LAST 6 MONTHS OR THERE IS A DOCUMENTED CONTRAINDICATION FOR THE USE OF 2 OF THE FORMULARY ALTERNATIVES (LAMOTRIGINE, GABAPENTIN, LEVETIRACETAM, OXCARBAZEPINE, TOPIRAMATE, CARBAMAZEPINE, ZONISAMIDE)

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
NEUROLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
ADJUNCTIVE THERAPY ONLY FOR THE DIAGNOSIS OF PRIMARY GENERALIZED TONIC-CLONIC SEIZURES
MEDICATION(S)
PERTJETA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HER 2 POSITIVE METASTATIC BREAST CANCER: PATIENT SHOULD NOT HAVE RECEIVED PRIOR ANTI-HER2 THERAPY OR CHEMOTHERAPY FOR METASTATIC DISEASE. MUST BE USED IN COMBINATION WITH TRASTUZUMAB (HERCEPTIN) AND DOCETAXEL (TAXOTERE).
HER2 POSITIVE EARLY STAGE BREAST CANCER: BEING USED PRIOR TO SURGERY (NEOADJUVANT) FOR NODE POSITIVE DISEASE OR FOR A TUMOR MORE THAN 2 CM IN DIAMETER OR BEING USED POST-SURGERY (ADJUVANT). MUST BE USED ALONG WITH HERCEPTIN AS PART OF A COMPLETE TREATMENT REGIMEN THAT INCLUDES OR HAS INCLUDED CYTOTOXIC CHEMOTHERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PLAN YEAR

OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B.
PEXIDARTINIB (TURALIO)

MEDICATION(S)
TURALIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Not being used with imatinib

REQUIRED MEDICAL INFORMATION
Tenosynovial giant cell tumor (TGCT): surgery is not an option.

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
Orthopedic surgeon or oncologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
PIMAVANSEIN (NUPLAZID)

MEDICATION(S)
NUPLAZID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED FOR DEMENTIA-RELATED PSYCHOSIS.

REQUIRED MEDICAL INFORMATION
EVALUATION BY PSYCHIATRIST Confirms PARKINSON’S DISEASE PSYCHOSIS (PDP) – Symptons of HALLUCINATIONS (SEEING, HEARING, OR EXPERIENCING THINGS THAT OTHERS DON’T) AND DELUSIONS (BELIEVING THINGS THAT AREN’T TRUE) DUE TO PARKINSON’S DISEASE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST OR PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
PIMECROLIMUS (ELIDEL)

MEDICATION(S)
PIMECROLIMUS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF TRIAL AND FAILURE OF 2 TOPICAL CORTICOSTEROIDS, AT LEAST ONE OF THEM CLASS I OR II POTENCY (I.E. CLOBETASOL, BETHAMETASONE, FLUOCINONIDE, DESOXIMETHASONE ETC..) , OR CONTRAINDICATION TO TOPICAL CORTICOSTEROIDS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS, FOR REAUTHORIZATION, AFTER DOCUMENTATION OF RESPONSE TO THERAPY, APPROVE FOR 6 MONTHS

OTHER CRITERIA
N/A
PIRFENIDONE (ESBRIET)

MEDICATION(S)
ESBRIET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER IPF DRUG.
BEING USED FOR SEVERE IPF DISEASE WHERE FVC IS UNDER 50% OR DLCO IS UNDER 30%.

REQUIRED MEDICAL INFORMATION
IDIOPATHIC PULMONARY FIBROSIS (IPF), INITIAL USE: PATIENT HAS MILD TO MODERATE DISEASE CONFIRMED BY THE FOLLOWING PULMONARY FUNCTION TESTS: FORCED VITAL CAPACITY (FVC) EQUAL OR OVER 50%, AND DIFFUSING CAPACITY OF CARBON MONOXIDE (DLCO) EQUAL OR OVER 30%.
ONGOING USE: PATIENT HAS NOT RECEIVED A LUNG TRANSPLANT, PATIENT CONTINUES TO HAVE MILD TO MODERATE IPF DISEASE CONFIRMED BY THE FOLLOWING PULMONARY FUNCTION TESTS: FVC EQUAL OR ABOVE 50% AND DLCO IS EQUAL OR OVER 30%.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PULMONOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
POLATUZUMAB VEDOTIN-PIIQ (POLIVY)

MEDICATION(S)
POLIVY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diffuse large B-cell lymphoma (DLBCL) or high-grade B-cell lymphoma (HGBL): being used with bendamustine and a rituximab product, cancer has relapsed or did not respond to at least two prior anti-cancer drug regimens, and autologous hematopoietic stem cell transplant is option.

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
POMALIDOMIDE (POMALYST)

MEDICATION(S)
POMALYST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
ICLUSIG

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
PRAMLIINTIDE (SYMLIN)

MEDICATION(S)
SYMLINPEN 120, SYMLINPEN 60

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
RAMUCIRUMAB (CYRAMZA)

MEDICATION(S)
CYRAMZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
COLORECTAL CANCER: PATIENT HAS BEEN TREATED WITH AN IRINOTECAN-CONTAINING REGIMEN.

REQUIRED MEDICAL INFORMATION
METASTATIC COLORECTAL CANCER (MCRC): PATIENT HAS A MEDICAL REASON FOR NOT USING AN AVASTIN-CONTAINING REGIMEN.
HEPATOCELLULAR CARCINOMA (LIVER CANCER): SECOND-LINE TREATMENT FOR LIVER CANCER THAT CANNOT BE REMOVED BY SURGERY AND ALPHA-FETOPROTEIN (AFP) LEVEL IS 400 NG/ML OR MORE AND BEING USED AS A SINGLE AGENT.
ESOPHAGEAL, ESOPHAGOGASTRIC-JUNCTION, AND GASTRIC CANCER: SINGLE AGENT OR WITH PACLITAXEL, DISEASE PROGRESSED ON OR AFTER USE OF FLUOROPYRIMIDINE- OR PLATINUM-BASED REGIMEN FOR ADVANCED DISEASE (RECURRENT OR METASTATIC).
NON-SMALL CELL LUNG CANCER (NSCLC): BEING USED WITH DOCETAXEL, DISEASE PROGRESSED ON OR AFTER USE OF PLATINUM-BASED CHEMOTHERAPY FOR RECURRENT, ADVANCED OR METASTATIC NSCLC AND IF EGFR OR ALK-POSITIVE DISEASE PROGRESSED ON FDA APPROVED TARGETED THERAPY PRIOR TO CYRAMZA USE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS
OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
REGORAFENIB (STIVARGA)

MEDICATION(S)
STIVARGA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HEPATOCELLULAR CARCINOMA (LIVER CANCER): BEING USED AS A SINGLE AGENT AND PATIENT HAS HAD PRIOR THERAPY FOR LIVER CANCER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
RIBASPHERE, RIBAVIRIN 200 MG CAPSULE, RIBAVIRIN 200 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF HEPATITIS C AND BASELINE HCV RNA, ALT, AST LEVEL, GENOTYPE, WEIGHT

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST, INFECTIOUS DISEASE OR HEPATOLOGIST

COVERAGE DURATION
DURATION DEPENDANT ON GENOTYPE AND OTHER HCV ANTIVIRAL DRUGS, WILL FOLLOW AASLD GUIDELINES

OTHER CRITERIA
FOR HEP C DUAL THERAPY WITH PEGINTERFERON HAS TO ACHIEVE AN EARLY VIRAL RESPONSE (EVR) DEFINED AS A MINIMUM 2 LOG DECREASE IN VIRAL LOAD DURING THE FIRST 12 WEEKS OF TREATMENT FOR ADDITIONAL APPROVAL
RIBOCICLIB (KISQALI)

MEDICATION(S)
KISQALI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
RIFAXIMIN (XIFAXAN)

MEDICATION(S)
XIFAXAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRAVELERS DIARRHEA: PATIENT HAS TRIED AZITHROMYCIN OR A FLUOROQUINOLONE LIKE CIPROFLOXACIN OR HAS A MEDICAL REASON NOT TO USE CIPROFLOXACIN AND AZITHROMYCIN. HEPATIC ENCEPHALOPATHY: PATIENT HAS TRIED LACTULOSE. IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D): PATIENT HAS TRIED AN ANTI-DIARRHEAL DRUG (DIPHENOXYLATE/ATROPINE, LOPERAMIDE) OR HAS A MEDICAL REASON NOT TO USE (CONTRAINDICATION) ANTI-DIARRHEAL THERAPIES.

AGE RESTRICTION
TRAVELERS DIARRHEA: 12 YEARS OF AGE OR OLDER. HEPATIC ENCEPHALOPATHY & IBS-D: 18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
TRAVELERS DIARRHEA: 3 days
HEPATIC ENCEPHALOPATHY: 12 MONTHS
IBS-D: 2 WEEKS

OTHER CRITERIA
N/A
RILONACEPT (ARCALYST)

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
PATIENT IS 12 YEARS OLD OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
RIOCIGUAT (ADEMPAS)

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH A PDE-5 INHIBITOR.

REQUIRED MEDICAL INFORMATION
CONFIRMATION OF PULMONARY ARTERIAL HYPERTENSION (WHO GROUP I) BY RIGHT HEART CATHETERIZATION TEST AND PATIENT HAS TRIED AN ENDOTHELIN-RECEPTOR ANTAGONIST (E.G. TRACLEER) AND A PHOSPHODIESTERASE TYPE 5 (PDE-5) INHIBITOR (E.G. SILDENAFIL).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
RISPERIDONE (PERSERIS ER SQ)

MEDICATION(S)
PERSERIS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
OLDER ADULTS (65 YEARS AND OLDER) WITH DEMENTIA-RELATED PSYCHOSIS.

REQUIRED MEDICAL INFORMATION
TREATMENT FAILURE WITH AT LEAST ONE ORAL ATYPICAL ANTIPSYCHOTIC (RISPERIDONE, ZIPRASIDONE, QUETIAPINE, OLANZAPINE, ARIPIPRAZOLE) AND MEDICAL REASON WHY INJECTABLE RISPERIDONE (RISPERDAL CONSTA) CANNOT BE USED.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
PSYCHIATRIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
RITUXIMAB (RITUXAN)

MEDICATION(S)
RITUXAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
RA: NOT BEING USED WITH ANOTHER TARGETED IMMUNOTHERAPY.

REQUIRED MEDICAL INFORMATION
RHEUMATOID ARTHRITIS (RA): PATIENT HAS TRIED ONE DMARD OR MEDICAL REASON WHY METHOTREXATE, HYDROXYCHLOROQUINE, AND SULFASALAZINE CANNOT BE USED AND HAS A MEDICAL REASON WHY TNF BLOCKERS [E.G. ENBREL, HUMIRA, REMICADE] CANNOT BE USED.
IDIOPATHIC THROMBOCYTOPENIC PURPURA (ITP): PLATELET COUNT IS LESS THAN 30,000/MCL, AND PATIENT HAS TRIED AT LEAST ONE OF THE FOLLOWING TREATMENTS: CORTICOSTEROIDS, IVIG, ANTI-D ANTIBODY, OR SPLENECTOMY, OR HAS A MEDICAL REASON WHY THESE CANNOT BE USED.
SOLID ORGAN TRANSPLANT: DOCUMENTATION OF USE BEFORE OR DURING SURGERY FOR PREVENTION OR USE IS FOR TREATMENT OF ANTIBODY-MEDICATED REJECTION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA: RHEUMATOLOGIST

COVERAGE DURATION
AIHA/ITP: ONE COURSE
RA/NHL: 12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
RITUXIMAB-PVVR (RUXIENCE)

MEDICATION(S)
RUXIENCE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
RA: being used with another targeted immunotherapy.

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis (RA): patient has tried one DMARD or medical reason why methotrexate, hydroxychloroquine, and sulfasalazine cannot be used AND has a medical reason why TNF blockers (e.g. Enbrel, Humira, Remicade) cannot be used.
Idiopathic Thrombocytopenic Purpura (ITP): platelet count is less than 30,000/mcl, and patient has tried at least one of the following treatments: corticosteroids, IVIG, anti-D antibody, or splenectomy, or has a medical reason why these cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA: Rheumatologist

COVERAGE DURATION
AIHA/ITP: one course
RA/NHL/CLL/SLL: plan year

OTHER CRITERIA
Excluded under Part D if covered by Part B.
ROFLUMILAST (DALIRESP)

**MEDICATION(S)**
DALIRESP

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTATION OF EXACERBATION OF COPD DESPITE USE OF MAX DOSE BRONCHODILATORS AND INHALED CORTICOSTEROIDS FOR MINIMUM OF 3 MONTHS, OR CONTRAINDICATION OR INTOLERANCE TO ABOVE AGENTS. DOCUMENTATION SHOWING FEV1 LESS THAN 50% PREDICTED

**AGE RESTRICTION**
NOT APPROVED FOR PEDIATRIC PATIENTS

**PRESCRIBER RESTRICTION**
PULMONOLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
FOR REAUTHORIZATIONS, IF DOCUMENTATION IF POSITIVE RESPONSE TO THERAPY, APPROVE FOR 12 MONTHS
ROSIGLITAZONE MALEATE (AVANDIA)

MEDICATION(S)
AVANDIA 2 MG TABLET, AVANDIA 4 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TYPE 2 DIABETES: PATIENT HAS INADEQUATE RESPONSE, INTOLERABLE SIDE EFFECT OR CONTRAINICATION TO PIOGLITAZONE AND DOSE DOES NOT EXCEED THE FDA LABEL MAXIMUM.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
IF STARTING THERAPY: PATIENT MUST BE RULED AS NOT HAVING CHF, HISTORY OF ANGINA AND MI. IF ONGOING THERAPY: REGULAR CARDIAC EVALUATION MUST TAKE PLACE.
RUCAPARIB CAMSYLATE (RUBRACA)

MEDICATION(S)
RUBRACA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED AS PART OF A MULTI-CANCER DRUG REGIMEN.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
RUFINAMIDE (BANZEL)

MEDICATION(S)
BANZEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED FAILURE ON 2 OF THE FOLLOWING FORMULARY FIRST LINE ANTIEPILEPTICS INDICATED FOR LENNOX-GASTAUT SYNDROME: VALPROIC ACID, LAMOTRIGINE, TOPIRAMATE, FELBAMATE, CLONAZEPAM.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
RUXOLITINIB (JAKAFI)

MEDICATION(S)
JAKAFI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MYELOFIBROSIS (MF), INITIAL USE: PATIENT HAS ENLARGED SPLEEN AND PLATELET COUNT IS EQUAL TO OR MORE THAN 50,000 CELLS/MCL. ONGOING USE: CURRENT PLATELET COUNT IS AT LEAST 50,000 CELLS/MCL AND PRESCRIBER STATES THE PATIENT’S SYMPTOMS HAVE IMPROVED (I.E. FEVER, NIGHT SWEATS, BONE OR MUSCLE PAIN, EARLY SATIETY, ABDOMINAL DISCOMFORT) OR SPLEEN SIZE HAS REDUCED.
POLYCYTHEMIA VERA (PV), ONGOING USE: PRESCRIBER STATES THE PATIENT’S SPLEEN SIZE, VOLUME, LENGTH HAS REDUCED OR HEMATOCRIT IS LESS THAN 45% AND PATIENT HAS NOT REQUIRED PHLEBOTOMY (TAKing BLOOD FROM THE VEIN).
GRAFT VS HOST DISEASE (GVHD): TREATMENT FAILURE WITH SYSTEMIC CORTICOSTEROIDS (E.G. PREDNISONE, METHYLprednisolone).

AGE RESTRICTION
All other conditions: 18 years of age or older.
GvHD: 12 years of age or older.

PRESCRIBER RESTRICTION
MF: HEMATOLOGIST OR ONCOLOGIST PV: HEMATOLOGIST

COVERAGE DURATION
Initial: MF - 6 months, PV- 8 months
MF, PV ongoing use: plan year
GvHD: plan year
OTHER CRITERIA
N/A
SACROSIDASE (SU CRAID)

MEDICATION(S)
SU CRAID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL USE: PATIENT HAS BEEN EVALUATED TO RULE OUT OTHER CAUSES OF DISACCHARIDASE DEFICIENCY. ONGOING USE: PATIENT'S GASTROINTESTINAL SYMPTOMS (I.E. ABDOMINAL PAIN, DIARRHEA, WATERY STOOLS, BLOATING, FLATULENCE) HAVE BEEN REDUCED.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST, GENETICIST, OR METABOLIC SPECIALIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
SAPROPTERIN DIHYDROCHLORIDE (KUVAN)

MEDICATION(S)
KUVAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PHENYLKETONURIA (PKU), INITIAL: CHART NOTES CONFIRM PKU, DOSE DOES NOT EXCEED 10MG/KG PER DAY, AND BASELINE (JUST PRIOR TO THERAPY) AND TARGET BLOOD PHENYLALANINE (PHE) LEVELS ARE GIVEN. PKU, DOSE INCREASES: PHENYLALANINE LEVEL IS NOT AT TARGET RANGE OR THERE IS LESS THAN A 20% LOWERING OF PHE LEVEL AT A DOSE THAT IS LESS THAN 20MG/KG/DAY. PKU, ONGOING USE: RECENT PHENYLALANINE LEVEL IS AT TARGET RANGE OR THERE IS AT LEAST A 20% LOWERING IN PHE LEVEL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 3 months; dose increases: 3 months, ongoing use: plan year

OTHER CRITERIA
N/A
SARGRAMOSTIM (LEUKINE)

MEDICATION(S)
LEUKINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
NEUTROPENIA DUE TO RADIATION: LENGTH OF RADIATION
CHEMO INITIAL: 14 DAYS ONGOING: LENGTH OF CHEMO

OTHER CRITERIA
N/A
**SARILUMAB (KEVZARA)**

**MEDICATION(S)**
KEVZARA 150 MG/1.14 ML SYRINGE, KEVZARA 200 MG/1.14 ML SYRINGE

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RA AND DOCUMENTATION OF TRIAL AND FAILURE OR INTOXERANCE TO AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, SULFASALAZINE, AZATHIOPRINE, OR CYCLOSPORINE MODIFIED) AND NO ACTIVE INFECTION

**AGE RESTRICTION**
NOT APPROVED IN PEDIATRIC PATIENTS

**PRESCRIBER RESTRICTION**
RHEUMATOLOGIST

**COVERAGE DURATION**
6 MONTHS

**OTHER CRITERIA**
FOR RE-AUTHORIZATION REQUEST DOCUMENTATION SHOWING IMPROVEMENT AND EXTEND AUTHORIZATION BY 6 MONTHS INCREMENTS.
SELEGILINE TRANSDERMAL (EMSAM)

MEDICATION(S)
EMSAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF TRIAL AND FAILURE OR CONTRAINDICATION TO ONE SSRI (IE FLUOXETINE, SERTRALINE, PAROXETINE, CITALORAM ETC.) AND ONE SNRI (IE VENLAFAXINE, DULOXETINE ETC..)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
UPTRAVID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER PROSTACYCLIN DRUG (E.G. REMODULIN, VENTAVIS).

REQUIRED MEDICAL INFORMATION
PULMONARY ARTERIAL HYPERTENSION (WHO GROUP 1): DIAGNOSIS CONFIRMED BY RIGHT HEART CATHETERIZATION, AND PATIENT HAS TRIED OR HAS A MEDICAL REASON NOT TO USE AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G. LETAIRIS, OPSUMIT, TRACLEER) AND A PHOSPHODIESTERASE TYPE 5 (PDE-5) INHIBITOR (E.G. ADCIRCA, REVATIO).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
SELINEXOR (XPOVIO)

**MEDICATION(S)**
XPOVIO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
Being used by itself or with another drug that is not dexamethasone.

**REQUIRED MEDICAL INFORMATION**
Multiple myeloma: cancer has relapsed or did not respond to at least four prior anti-cancer drug regimens. Disease is resistant to other forms of treatment, including at least 2 proteasome inhibitors, 2 immunomodulatory agents, and an anti-CD38 monoclonal antibody.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

**OTHER CRITERIA**
N/A
SELUMETINIB (KOSELUGO)

MEDICATION(S)
KOSELUGO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
SILDENAFIL (REVATIO)

MEDICATION(S)
SILDENAFIL 20 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH ANOTHER PHOSPHODIESTERASE (PDE) TYPE 5 INHIBITOR OR WITH A GUANYLATE CYCLASE STIMULATOR AGENT.

REQUIRED MEDICAL INFORMATION
CONFIRMATION OF PULMONARY ARTERIAL HYPERTENSION (WHO GROUP I) BY RIGHT HEART CATHETERIZATION TEST.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
SILTUXIMAB (SYLVANT)

MEDICATION(S)
SYLVANT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
SODIUM OXYBATE (XYREM)

MEDICATION(S)
XYREM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PRE-REQUISITE DRUG NOT REQUIRED FOR CATAPLEXY BUT FOR THE TREATMENT OF NARCOLEPSY: TRIAL AND FAILURE OR INTOLERANCE TO STIMULANTS (SUCH AS DEXTROAMPHETAMINE/AMPHETAMINE, METHYLPHENIDATE OR DEXTROAMPHETAMINE) AND MODAFINIL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGIST OR SLEEP SPECIALIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
SODIUM PHENYL BUTYRATE (BUPHENYL)

**MEDICATION(S)**
SODIUM PHENYL BUTYRATE 500MG TB

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
CHART DOCUMENTATION FOR INHERITED UREA CYCLE ENZYME DEFICIENCY.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
SOFOSBUVIR/VELPATASVIR (EPCLUSA)

MEDICATION(S)
EPCLUSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
EXCLUSION CRITERIA WILL BE BASED ON CURRENT AASLD/IDSA GUIDELINES.

REQUIRED MEDICAL INFORMATION
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH CURRENT AASLD/IDSA GUIDELINES.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
HEPATOLOGIST, GASTROENTEROLOGIST, OR INFECTIOUS DISEASE.

COVERAGE DURATION
LENGTH OF THERAPY WILL BE BASED ON CURRENT AASLD/IDSA GUIDELINES AND FDA LABELING.

OTHER CRITERIA
N/A
SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR (VOSEVI)

**MEDICATION(S)**
VOSEVI

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
EXCLUSION CRITERIA WILL BE BASED ON CURRENT AASLD/IDSA GUIDELINES.

**REQUIRED MEDICAL INFORMATION**
REQUIRED MEDICAL INFORMATION WILL BE ALIGNED WITH CURRENT AASLD/IDSA GUIDELINES.

**AGE RESTRICTION**
18 YEARS OF AGE OR OLDER.

**PRESCRIBER RESTRICTION**
HEPATOLOGIST, GASTROENTEROLOGIST, OR INFECTIOUS DISEASE.

**COVERAGE DURATION**
LENGTH OF THERAPY WILL BE BASED ON CURRENT AASLD/IDSA GUIDELINES AND FDA LABELING.

**OTHER CRITERIA**
N/A
SOMATROPIN (SEROSTIM)

MEDICATION(S)
SEROSTIM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HIV-ASSOCIATED WASTING OR CACHEXIA, INITIAL USE: PATIENT WEIGHS LESS THAN 90% IDEAL BODY WEIGHT OR HAS LOST GREATER THAN OR EQUAL TO 10% OF USUAL BODY WEIGHT OR HAS A BASELINE BIA OR TOTAL BODY DEXA SHOWING BODY CELL MASS BELOW 40% IN MALES AND 35% IN FEMALES. ONGOING USE: IMPROVEMENT IN THE BODY WEIGHT OR BODY CELL MASS (BCM) COMPARED TO BASELINE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 WEEKS

OTHER CRITERIA
N/A
SOMATROPIN (SOMATROPIN)

MEDICATION(S)
GENOTROPIN, HUMATROPE, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN 10 INJECTOR,
NUTROPIN AQ NUSPIN 20 INJECTOR, SAIZEN, SAIZEN-SAIZENPREP, ZORBIVIVE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A
REQUIRED MEDICAL INFORMATION

GROWTH HORMONE DEFICIENCY (GHD) WITH PITUITARY DISEASE: ADULTS - EVIDENCE OF PITUITARY DISEASE AND FAILED ONE STANDARD GROWTH HORMONE STIM TEST WITHIN ONE YEAR OF STARTING GROWTH HORMONE. PEDS - EVIDENCE OF PITUITARY DISEASE, GROWTH VELOCITY DECLINE, AND FAILED ONE STANDARD GROWTH HORMONE STIM TEST. GHD WITHOUT PITUITARY DISEASE: ADULTS - THERE IS AT LEAST ONE DOCUMENTED PITUITARY HORMONE DEFECT, IGF-1 IS BELOW MEAN OF REFERENCE RANGE (BELOW 50TH PERCENTILE) AND HAS FAILED ONE GH STIM TEST OR THERE ARE THREE OR MORE DOCUMENTED PITUITARY HORMONE DEFECTS AND IGF-1 IS OUTSIDE OF REFERENCE RANGE FOR SEX/AGE. PEDS - HEIGHT IS LESS THAN 3RD PERCENTILE FOR AGE/SEX, HEIGHT VELOCITY IS LESS THAN 10TH PERCENTILE OF NORMAL FOR AGE/SEX TRACKED OVER AT LEAST ONE YEAR, AND EITHER FAILED TWO STANDARD GROWTH HORMONE STIM TESTS OR FAILED ONE STANDARD GROWTH HORMONE STIM TEST AND HAS LOW IGF-1. GHD CONTINUING FROM CHILDHOOD, INITIAL: EVIDENCE OF PITUITARY DISEASE OR PATIENT FAILED ONE STANDARD GROWTH HORMONE STIM TEST AFTER THE AGE OF 18 AND WITHIN ONE YEAR OF STARTING GROWTH HORMONE THERAPY. FOR ONGOING USE: PRESCRIBER STATES PATIENT RESPONDED TO THERAPY. SMALL FOR GESTATIONAL AGE (SGA): PATIENTS LENGTH AT BIRTH OR BIRTH WEIGHT ARE TWO OR MORE STANDARD DEVIATIONS BELOW THE MEAN (LESS THAN THE 3RD PERCENTILE) FOR GESTATIONAL AGE (ADJUSTED FOR PREMATURITY) AND PATIENTS HEIGHT IS TWO OR MORE STANDARD DEVIATIONS BELOW THE MEAN. ONGOING USE IN SGA OR PED GHD: GROWTH VELOCITY IMPROVED WHILE ON GH. ONGOING USE FOR PEDIATRICS WITH GROWTH FAILURE DUE TO CHRONIC KIDNEY DISEASE: PATIENT DID NOT HAVE A KIDNEY TRANSPLANT WITHIN THE PAST YEAR. ONGOING USE FOR TURNERS OR PRADER-WILLI SYNDROME: PRESCRIBER HAS DETERMINED THAT BENEFITS OUTWEIGHT RISK AND CONTINUATION IS NECESSARY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ADULT GHD: ENDOCRINOLOGIST TURNERS SYNDROME, PRADER-WILLI SYNDROME, PED GHD, SGA: PEDIATRIC ENDOCRINOLOGIST

COVERAGE DURATION
12 WEEKS FOR SEROSTIM AND 12 MONTHS FOR OTHER CONDITIONS

OTHER CRITERIA
N/A
SONIDEGIB (ODOMZO)

MEDICATION(S)
ODOMZO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT HAS USED A HEDGEHOG INHIBITOR (E.G. ERIVEDGE).
BEING USED AS PART OF A MULTI-DRUG CHEMOTHERAPY REGIMEN.

REQUIRED MEDICAL INFORMATION
INITIAL USE: PATIENT STILL HAS DISEASE DESPITE SURGERY OR RADIATION THERAPY AND
PATIENT IS NOT A CANDIDATE FOR FURTHER SURGERY OR RADIATION THERAPY.
FOR ONGOING USE: DISEASE HAS NOT WORSENED SINCE STARTING ODOMZO.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
INITIAL: 6 MONTHS
ONGOING USE: 12 MONTHS

OTHER CRITERIA
N/A
SORAFENIB (NEXAVAR)

MEDICATION(S)
NEXAVAR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
KIDNEY CANCER (RENAL CELL CARCINOMA): CANCER CANNOT BE TREATED WITH SURGERY (UNRESECTABLE DISEASE) OR PATIENT IS NOT A CANDIDATE FOR SURGERY.
LIVER CANCER (HEPATOCELLULAR CARCINOMA): UNRESECTABLE DISEASE OR PATIENT IS NOT A CANDIDATE FOR SURGERY AND IS BEING USED AS A SINGLE AGENT.
THYROID CANCER, MEDULLARY DISEASE: PATIENT HAS TRIED CAPRELSA OR COMETRIQ.
GASTROINTESTINAL STROMAL TUMOR (GIST): TREATMENT FAILURE WITH IMATINIB AND SUTENT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
SULFONYLUREAS, LONG ACTING (HIGH RISK MEDICATION)

**MEDICATION(S)**
GLYBURIDE, GLYBURIDE MICRONIZED, GLYBURIDE-METFORMIN HCL

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Patient has tried glipizide or glipizide/metformin and prescriber confirms the benefits of the drug outweigh any risks and will monitor for side effects.

**AGE RESTRICTION**
65 years and older.
No prior authorization required for less than 65 years old.

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
SUNITINIB MALATE (SUTENT)

**MEDICATION(S)**
SUTENT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
KIDNEY CANCER (RENAL CELL CARCINOMA): CANCER CANNOT BE TREATED WITH SURGERY (UNRESECTABLE DISEASE) OR PATIENT IS NOT A CANDIDATE FOR SURGERY.
LIVER CANCER (HEPATOCELLULAR CARCINOMA): UNRESECTABLE DISEASE OR PATIENT IS NOT A CANDIDATE FOR SURGERY AND IS BEING USED AS A SINGLE AGENT.
THYROID CANCER, MEDULLARY DISEASE: PATIENT HAS TRIED CAPRELSA OR COMETRIQ.
GASTROINTESTINAL STROMAL TUMOR (GIST): TREATMENT FAILURE WITH IMATINIB AND SUTENT.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
TACROLIMUS (ASTAGRAF)

MEDICATION(S)
ASTAGRAF XL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IF REQUESTED FOR ORGAN TRANSPLANTATION PROPHYLAXIS OTHER THAN KIDNEY TRANSPLANT

REQUIRED MEDICAL INFORMATION
REQUEST HAS TO BE FOR PROPHYLAXIS OF ORGAN REJECTION IN PATIENTS RECEIVING A KIDNEY TRANSPLANT WITH MYCOPHENOLATE MOFETIL AND CORTICOSTEROIDS. REQUIRE DOCUMENTATION OF FAILURE ON OR CONTRAINDICATION TO THE USE OF IMMEDIATE RELEASE TACROLIMUS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NOT APPROVED IF CONCOMITANT CYCLOSPORINE THERAPY. NOT APPROVED IF COVERED UNDER PART B.
TACROLIMUS  (ENVARSUS)

MEDICATION(S)
ENVARSUS XR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PATIENT HAS TRIED IMMEDIATE-RELEASE (IR) TACROLIMUS OR HAS A MEDICAL REASON FOR NOT USING IR TACROLIMUS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
TACROLIMUS GRANULES (PROGRAF)

MEDICATION(S)
PROGRAF 0.2 MG GRANULE PACKET, PROGRAF 1 MG GRANULE PACKET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PATIENT HAS A MEDICAL REASON FOR NOT USING TACROLIMUS CAPSULES. PATIENT HAS A MEDICAL REASON FOR NOT USING TACROLIMUS CAPSULES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
TACROLIMUS OINTMENT (PROTOPI

**MEDICATION(S)**
TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DOCUMENTATION OF TRIAL AND FAILURE OF 2 TOPICAL CORTICOSTEROIDS, AT LEAST ONE OF THEM CLASS I OR II POTENCY (I.E. CLOBETASOL, BETHAMETASONE, FLUOCINONIDE, DESOXIMETHASONE ETC..) , OR CONTRAINDICATION TO TOPICAL CORTICOSTEROIDS

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
3 MONTHS, FOR REAUTHORIZATION, AFTER DOCUMENTATION OF RESPONSE TO THERAPY, APPROVE FOR 6 MONTHS

**OTHER CRITERIA**
N/A
TADALAFIL (ADCIRCA, ALYQ)

**MEDICATION(S)**
ALYQ, TADALAFIL 20 MG TABLET

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
PULMONARY ARTERIAL HYPERTENSION: BEING USED WITH ANOTHER PHOSPHODIESTERASE (PDE) TYPE 5 INHIBITOR OR WITH A GUANYLATE CYCLASE STIMULATOR AGENT. REYNAUD’S PHENOMENON: BEING WITH ANOTHER PHOSPHODIESTERASE INHIBITOR (E.G. SILDENAFIL).

**REQUIRED MEDICAL INFORMATION**
CONFIRMATION OF PULMONARY ARTERIAL HYPERTENSION (WHO GROUP I) BY RIGHT HEART CATHETERIZATION TEST. RAYNAUD’S PHENOMENON: TREATMENT FAILURE OR SIDE EFFECT WITH A CALCIUM-CHANNEL BLOCKER (E.G. NIFEDIPINE).

**AGE RESTRICTION**
PATIENT IS 18 YEARS OF AGE OR OLDER

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
TAFAMIDIS (VYNDAMAX)

MEDICATION(S)
VYNDAMAX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Prior liver or heart transplant.
Being used with a gene silencer like Tegsedi or Onpattro.
New York Heart Association (NYHA) Class IV heart disease.

REQUIRED MEDICAL INFORMATION
Heart disease (cardiomyopathy) is due to transthyretin-mediated amyloidosis (ATTR) confirmed by clinical features, genetic testing, and biopsy or immunochemistry.

AGE RESTRICTION
18 years of age and older

PRESCRIBER RESTRICTION
Cardiologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
TAFAMIDIS MEGLUMINE (VYNDAQEL)

MEDICATION(S)
VYNDAQEL

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Prior liver or heart transplant. Being used with a gene silencer like Tegsedi or Onpattro. New York Heart Association (NYHA) Class IV heart disease.

REQUIRED MEDICAL INFORMATION
Heart disease (cardiomyopathy) is due to transthyretin-mediated amyloidosis (ATTR) confirmed by clinical features, genetic testing, and biopsy or immunochemistry.

AGE RESTRICTION
18 years of age and older

PRESCRIBER RESTRICTION
Cardiologist

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
TALAZOPARIB TOSYLATE (TALZENNA)

**MEDICATION(S)**
TALZENNA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
MEDICATION(S)
IMLYGIC

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED IN IMMUNOCOMPROMISED PATIENTS (HX IF PRIMARY OR ACQUIRED IMMUNE DEFICIENT-STATES), LEUKEMIA, LYMPHOMA, AIDS OR OTHER MANIFESTATIONS WITH HIV, OR ON IMMUNOSUPPRESSIVE THERAPY OR PREGNANCY.

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT THE MEDICATION IS REQUESTED FOR THE LOCAL TX OF UNRESECTABLE CUTANEOUS, SUBCUTANEOUS, AND NODAL LESIONS IN PATIENTS WITH MELANOMA RECURRENT AFTER SURGERY.

AGE RESTRICTION
NOT APPROVED IN PEDIATRIC PATIENTS

PRESCRIBER RESTRICTION
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
TAMOXIFEN CITRATE  (SOLTAMOX)

MEDICATION(S)
SOLTAMOX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE OR DOCUMENTED CONTRAINDICATION TO TABLET FORM OF TAMOXIFEN

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TASIMELTEON (HETLIOZ)

MEDICATION(S)
HETLIOZ

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL USE: PATIENT IS BLIND AND NOT ABLE TO PERCEIVE LIGHT AND MAINTAIN A STABLE 24-HOUR SLEEP-WAKE PATTERN SYNCHRONIZED TO 24-HR LIGHT/DARK CYCLE. ongoing use: patient's total sleep time at night is longer and has less day time sleep since starting Hetlioz.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
INITIAL USE: 3 MONTHS, ONGOING USE: 12 MONTHS

OTHER CRITERIA
N/A
TAZAROTENE (TAZORAC)

MEDICATION(S)
TAZAROTENE, TAZORAC 0.05% CREAM, TAZORAC 0.05% GEL, TAZORAC 0.1% GEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE OR CONTRAINDICATION TO THE FOLLOWING: FOR ACNE VULGARIS: TRETINOIN AND A TOPICAL ACNE MEDICATION (ADAPALENE, CLINDAMYCIN, ERYTHROMYCIN, ERYTHROMYCIN-BENZOYL PEROXIDE). FOR PSORIASIS: 2 TOPICAL CORTICOSTEROIDS, AT LEAST ONE OF THEM CLASS I OR II POTENCY (I.E. CLOBETASOL, BETHAMETASONE, FLUOCINONIDE, DESOXIMETHASONE ETC.)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 MONTHS, FOR REAUTHORIZATION, AFTER DOCUMENTATION OF RESPONSE TO THERAPY, APPROVE FOR 6 MONTHS

OTHER CRITERIA
N/A
TAZEMETOSTAT (TAZVERIK)

MEDICATION(S)
TAZVERIK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used as part of a multi-drug regimen.

REQUIRED MEDICAL INFORMATION
Documentation to confirm patient is not a candidate to have the cancer removed by surgery.

AGE RESTRICTION
16 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
TBO-FILGRASTIM (GRANIX)

MEDICATION(S)
GRANIX 300 MCG/0.5 ML SAFE SYR, GRANIX 300 MCG/0.5 ML SYRINGE, GRANIX 480 MCG/0.8 ML SAFE SYR, GRANIX 480 MCG/0.8 ML SYRINGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR THE TX OF NEUTROPENIA FOR HIGH RISK CHEMOTHERAPY REGIMEN (OVER 20% RISK): DOCUMENTATION OF CHEMOTHERAPY REGIMEN AS WELL AS BASELINE CBC WITH DIFFERENTIAL AND PLATELET COUNT CONFIRMING NEUTROPENIA. TO PREVENT NEUTROPENIA IN PATIENT RECEIVING CHEMOTHERAPY WITH HIGH RISK (20%) OF DEVELOPING NEUTROPENIA: DOCUMENTATION OF CHEMOTHERAPY REGIMEN OR DOCUMENTATION OF HIGH RISK FACTOR SUCH AS AGE OVER 65, PREVIOUS CHEMOTHERAPY, PRE-EXISTING NEUTROPENIA, INFECTIONS OR WOUNDS OR BONE MARROW INVOLVEMENT, PREVIOUS NEUTROPENIC COMPLICATION OR POOR PERFORMANCE STATUS. NEUTROPENIA DUE TO HIV/AIDS, OR NEUTROPENIA CAUSED BY DRUGS OTHER THAN CANCER DRUGS: NO USE OF PEGFILGRASTIM WITHIN THE PAST 14 DAYS AND ABSOLUTE NEUTROPHIL COUNT (ANC) IS LESS THAN 800/MM3 OR ANC IS LESS THAN 1000/MM3 WITH NEUTROPENIA EXPECTED TO LAST MORE THAN 5 DAYS. MYELODYSPLASTIC SYNDROMES (MDS): MDS: ANC IS LESS THAN 800/MM3 OR ANC IS LESS THAN 1000/MM3 WITH NEUTROPENIA EXPECTED TO LAST MORE THAN 5 DAYS OR BEING USED WITH EPOETIN (E.G. RETACRIT) TO IMPROVE SYMPTOMS OF LOW RED BLOOD

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A
COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NOT APPROVED IF PART B
TEDIZOLID (SIVEXTRO)

MEDICATION(S)
SIVEXTRO 200 MG TABLET

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
C and S REPORT DOCUMENTS EITHER METHICILLIN-SUSCEPTIBLE STAPHYLOCOCCUS INFECTION (MSSA) OR STREPTOCOCCUS INFECTION OR ENTEROCOCCUS INFECTION AND SENSITIVITY TO TEDIZOLID. MUST HAVE CONTRAINDICATION OR C and S MUST SHOW RESISTANCE TO AT LEAST 2: CLINDAMYCIN, DOXYCYCLINE OR SULFAMETHOXAZOLE-TRIMETHOPRIM (FOR MRSA INFECTIONS) OR TO CLINDAMYCIN, DICLOXACILLIN, CEPIHALEXIN, DOXYCYCLINE, MINOCYLINE OR SULFAMETHOXAZOLE-TRIMETHOPRIM (FOR MSSA INFECTIONS).

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 DAYS

OTHER CRITERIA
N/A
TENOFOVIR ALAFENAMIDE (VEMLIDY)

MEDICATION(S)
VEMLIDY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
NOT APPROVED FOR USE ALONE IN PATIENTS WITH HIV INFECTIONS. NOT APPROVED IF CRCL BELOW 15ML/MIN OR IF DECOMPENSATED (CHILD-PUGH B OR C) HEPATIC IMPAIRMENT.

REQUIRED MEDICAL INFORMATION
LABS CONFIRMING CHRONIC HEPATITIS B INFECTION (HBSAG POSITIVE FOR MORE THAN 6 MONTHS WITH SERUM HBV DNA POSITIVE AND PERSISTENT OR INTERMITTENT ELEVATION OF ALT/AST OR LIVER BIOPSY SHOWING CHRONIC HEPATITIS B)

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST, HEPATOLOGIST OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TERIFLUNOMIDE (AUBAGIO)

MEDICATION(S)
AUBAGIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED WITH OTHER DISEASE-MODIFYING THERAPIES FOR RELAPSING MULTIPLE SCLEROSIS.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TERIPARATIDE (FORTEO)

MEDICATION(S)
FORTEO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
DIAGNOSIS OF PAGETS DISEASE, A HISTORY OF RADIATION THERAPY, BONE MALIGNANCY, A HISTORY OF HYPERCALCEMIA OR HYPERPARATHYROIDISM

REQUIRED MEDICAL INFORMATION
CURRENT BMD RESULTS (LESS THAN 2 YEARS OLD) REVEALING OSTEOPOROSIS (TSCORE -2.5 OR LOWER) AND HAS FAILED OR HAS A DOCUMENTED CONTRAINDICATION TO ORAL BISPHOSPHONATE THERAPY

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TESTOSTERONE (ANDRODERM)

MEDICATION(S)
ANDRODERM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
EXCLUDED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
TESTOSTERONE  (TESTOSTERONE GEL VOGELXO)

**MEDICATION(S)**
TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
DIAGNOSIS OF DEFICIENCY OR ABSENCE OF ENDOGENOUS TESTOSTERONE (HYPOGONADISM).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
6 MONTHS

**OTHER CRITERIA**
N/A
TESTOSTERONE CYPIONATE  (TESTOSTERONE CYPIONATE INJECTION)

MEDICATION(S)
TESTOSTERON CYP 1,000 MG/10 ML, TESTOSTERON CYP 2,000 MG/10 ML, TESTOSTERONE CYP 100 MG/ML, TESTOSTERONE CYP 200 MG/ML

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MORNING TOTAL SERUM TESTOSTERONE LESS THAN 300 NG/DL OR SERUM FREE TESTOSTERONE LESS THAN 50 PG/ML

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
TESTOSTERONE UNDECANOATE (AVEED)

MEDICATION(S)
AVEED

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MORNING TOTAL SERUM TESTOSTERONE LESS THAN 300 NG/DL OR SERUM FREE TESTOSTERONE LESS THAN 50 PG/ML

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NOT APPROVED IF COVERED UNDER PART B
TEZACAFTOR-IVACAFTOR (SYMDEKO)

**MEDICATION(S)**
SYMDEKO

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
BEING USED WITH ANOTHER CFTR POTENTIATOR DRUG (E.G. ORKAMBI).

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
6 YEARS OF AGE OR OLDER.

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
N/A
THALIDOMIDE (THALOMID)

MEDICATION(S)
THALOMID

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
THIOLA TIOPRONIN

MEDICATION(S)
THIOLA EC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
TOBRAMYCIN (TOBI)

MEDICATION(S)
TOBRAMYCIN 300 MG/5 ML AMPULE, TOBRAMYCIN PAK 300 MG/5 ML

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED FOR ACUTE TREATMENT OF AN INFECTION.

REQUIRED MEDICAL INFORMATION
PATIENT HAS CYSTIC FIBROSIS OR BRONCHIECTASIS AND COPY OF SPUTUM CULTURE POSITIVE FOR PSEUDOMONAS AERUGINOSA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TOFACITINIB CITRATE  (XELJANZ 10MG FOR ULCERATIVE COLITIS)

**MEDICATION(S)**
XELJANZ 10 MG TABLET

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
TRIAL AND FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR UC SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, MESALAMINE, SULFASALAZINE, OR BALSALAZIDE

**AGE RESTRICTION**
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

**PRESCRIBER RESTRICTION**
GASTROENTEROLOGIST

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
FOR REAUTHORIZATIONS, IF EXPERIENCED IMPROVEMENT, APPROVE FOR 12 MONTHS
TOFACITINIB CITRATE (XELJANZ)

MEDICATION(S)
XELJANZ 5 MG TABLET, XELJANZ XR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
RA/PSA: TRIAL AND FAILURE OF 1 DMARD AND 1 BIOLOGIC AGENT SUCH AS ENBREL, HUMIRA, REMICADE, SIMPONI, CIMZIA, ORENCIA, RITUXAN, ACTEMRA OR KINERET. UC: TRIAL AND FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, MESALAMINE, SULFASALAZINE, OR BALSALAZIDE.

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
RHEUMATOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR REAUTHORIZATIONS, IF EXPERIENCED IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT, IMPROVEMENT IN ULCERATIVE COLITIS, OR IF PATIENT STABLE ON MEDICATION, APPROVE FOR 12 MONTHS.
TOPIRAMATE (QUDEXY)

MEDICATION(S)
TOPIRAMATE ER

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE OR CONTRAINDICATION FOR THE USE OF IMMEDIATE RELEASE TOPIRAMATE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TRADECEDIN (YONDELIS)

MEDICATION(S)
YONDELIS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF DX OF UNRESECTABLE OR METASTATIC LEIOMYOSARCOMA OR LIPOSARCOMA AND DOCUMENTATION THAT PATIENT TRIED AND FAILED PRIOR ANTHRACYCLINE-CONTAINING CHEMOTHERAPY (SUCH AS DAUNORUBICIN, DOXORUBICIN, EPIRUBICIN)

AGE RESTRICTION
NOT APPROVED FOR PEDIATRIC PATIENTS

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
TRAMETINIB (MEKINIST)

MEDICATION(S)
MEKINIST

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ANAPLASTIC THYROID CANCER (ATC): BEING USED WITH TAFINLAR TO TREAT CANCER THAT HAS A BRAF GENE CHANGE (MUTATION) CALLED V600E AND HAS SPREAD LOCALLY OR TO OTHER PARTS OF THE BODY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TRASTUZUMAB AND HYALURONIDASE (HERCEPTIN HYLECTA)

**MEDICATION(S)**
HERCEPTIN HYLECTA

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
BREAST CANCER: CANCER IS HER2 POSITIVE CONFIRMED BY AN FDA APPROVED TEST AND MEDICAL REASON WHY HERCEPTIN IV (TRASTUZUMAB) CANNOT BE USED AND USE IS FOR EARLY STAGE WITH SURGERY OR FOR CANCER THAT HAS COME BACK (RECURRENT) OR SPREAD (METASTATIC).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
EXCLUDED UNDER PART D IF COVERED BY PART B.
TRETINOIN TOPICAL  (TRETINOIN)

MEDICATION(S)
AVITA 0.025% GEL, TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.05% GEL, TRETINOIN 0.1% CREAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
TRIAL AND FAILURE ON AT LEAST ONE TOPICAL AGENT (ADAPALENE, CLINDAMYIN, ERYTHROMYCIN, ERYTHROMYCIN-BENZOYL PEROXIDE )

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
N/A
TRIENTINE HCL (TRIENTINE HCL)

MEDICATION(S)
CLOVIQUE, SYPRINE, TRIENTINE HCL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TRIFLURIDINE/TIPIRACIL HCL (LONSURF)

MEDICATION(S)
LONSURF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
TRIMIPRAMINE MALEATE (SURMONTIL)

MEDICATION(S)
TRIMIPRAMINE MALEATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DUE TO INCREASED RISK FOR GERIATRIC POPULATION, FOR AGES 65 AND OLDER ONLY:
DOCUMENTATION THAT MEMBER WAS EVALUATED AND FOUND TO BE ABLE TO TOLERATE
ANTICHLINERGIC SIDE EFFECTS SUCH AS SEDATION, CONFUSION, URINARY RETENTION

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL AND FAILURE WITH A TCA (AMITRIPTYLINE, IMIPRAMINE, NORTRIPTYLINE, DOXEPIN,
DESIPRAMINE, OR CLOMIPRAMINE) AND AN SSRI/SNRI (CITALOPRAM, SERTRALINE,
PAROXETINE, FLUOXETINE, ESCITALOPRAM, FLUVOXAMINE, VENLAFAXINE, OR DULOXETINE)
TUCATINIB (TUKYSA)

MEDICATION(S)
TUKYSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
USTEKINUMAB SQ (STELARA)

MEDICATION(S)
STELARA 45 MG/0.5 ML SYRINGE, STELARA 45 MG/0.5 ML VIAL, STELARA 90 MG/ML SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Being used with another targeted immunotherapy drug.

REQUIRED MEDICAL INFORMATION
PLAQUE PSORIASIS (PSO), INITIAL USE: TREATMENT FAILURE OR SIDE EFFECT WITH ONE DMARD OR HAS A MEDICAL REASON WHY METHOTREXATE, CYCLOSPORINE, AND ACITRETIN CANNOT BE USED AND MODERATE TO SEVERE DISEASE CONFIRMED BY PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 10 OR MORE OR BODY SURFACE AREA (BSA) OF AT LEAST 3% OR SENSITIVE AREAS ARE INVOLVED OR DISEASE AFFECTS DAILY LIVING. PSO, ONGOING USE: PASI OR BSA IMPROVED WITH USE OF STELARA.
PSORIATIC ARTHRITIS (PSA): TREATMENT FAILURE OR SIDE EFFECT WITH ONE DMARD DRUG OR MEDICAL REASON WHY METHOTREXATE, LEFLUNOMIDE, AND SULFASALAZINE CANNOT BE USED.
CROHN’S DISEASE (CD), INITIAL USE: TRIAL AND FAILURE OR SIDE EFFECT WITH AN ORAL CORTICOSTEROID (E.G. PREDNISONE, BUDENONIDE EC) OR HAS A MEDICAL REASON WHY ORAL CORTICOSTEROIDS CANNOT BE USED AND SQ FORMULATION WILL BE STARTED AFTER INITIAL IV DOSE.
CD, ONGOING USE: SYMPTOM IMPROVEMENT WITH USE OF STELARA.
ULCERATIVE COLITIS (UC), INITIAL USE: DISEASE IS MODERATE TO SEVERE AND TREATMENT FAILURE OR SIDE EFFECT WITH ORAL CORTICOSTEROIDS OR IMMUNOMODULATOR DRUGS (E.G. AZATHIOPRINE OR MERCAPTOPURINE) OR HAS A MEDICAL REASON WHY THESE DRUGS CANNOT BE USED AND SQ FORMULATION WILL BE STARTED AFTER INITIAL IV DOSE.
UC, ONGOING USE: SYMPTOM IMPROVEMENT WITH USE OF STELARA.

AGE RESTRICTION
PSO: 12 YEARS OR OLDER.
PSA, CD, UC: 18 YEARS OR OLDER.
PRESCRIBER RESTRICTION
PsO: Dermatologist or Rheumatologist. PsA: Rheumatologist.

COVERAGE DURATION
PsO INITIAL USE: 28 WEEKS.
PsO ONGOING USE, CD, UC, AND PSA: PLAN YEAR.

OTHER CRITERIA
N/A
VANDETANIB (CAPRELSA)

MEDICATION(S)
CAPRELSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED AS PART OF A MULTI-DRUG CHEMO REGIMEN.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
VEMURAFENIB (ZELBORAF)

MEDICATION(S)
ZELBORAF

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
SKIN CANCER (MELANOMA): PATIENT’S CANCER DID NOT RESPOND TO PRIOR USE OF A BRAF OR MEK INHIBITOR.

REQUIRED MEDICAL INFORMATION
NON-SMALL CELL LUNG CANCER: BEING USED AS A SINGLE AGENT FOR RECURRENT, ADVANCED, OR METASTATIC DISEASE THAT HAS A CHANGE IN THE BRAF GENE CALLED V600E.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
VENETOCLAX (VENCLEXTA)

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ACUTE MYELOID LEUKEMIA (AML), USE IN COMBINATION WITH AZACITADINE OR DECITABINE OR LOW-DOSE CYTARABINE IN ADULT 75 YEARS OR OLDER OR 60 YEARS OR OLDER WITH COMORBIDITIES THAT DO NOT ALLOW FOR INTENSIVE INDUCTION CHEMOTHERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
VIGABATRIN (SABRIL)

MEDICATION(S)
VIGABATRIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR CONTINUED USE: ONGOING DIAGNOSIS OF INFANTILE SPASM IS CONFIRMED BY EEG OR PRESCRIBER PROVIDES MEDICAL REASON FOR CONTINUED USE.
COMPLEX PARTIAL SEIZURES: PATIENT HAS TRIED TWO OTHER DRUGS THAT STOP SEIZURES AND WILL BE USED WITH ANOTHER ANTI-SEIZURE DRUG.

AGE RESTRICTION
COMPLEX PARTIAL SEIZURES: 2 YEARS OF AGE OR OLDER. INFANTILE SPASMS: 2 YEARS OF AGE OR LESS.

PRESCRIBER RESTRICTION
INFANTILE SPASMS: NEUROLOGIST

COVERAGE DURATION
SEIZURES: ANNUAL
INFANTILE SPASMS: 6 MONTHS

OTHER CRITERIA
N/A
VILAZODONE HCL (VIIBRYD)

MEDICATION(S)
VIIBRYD

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED FAILURE ON 1 SSRI AND 1 SNRI

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
VINCRISTINE LIPOSOMAL (MARQIBO)

MEDICATION(S)
MARQIBO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED AS PART OF A MULTI-DRUG CHEMOTHERAPY REGIMEN.

REQUIRED MEDICAL INFORMATION
ACUTE LYMPHOBLASTIC LEUKEMIA: PATIENT IS PHILADELPHIA CHROMOSOME POSITIVE AND PATIENT HAS TRIED A TYROSINE KINASE INHIBITOR (E.G. IMATINIB).

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
MEDICATION(S)
ERIVEDGE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
BEING USED AS PART OF A MULTI-AGENT CHEMO REGIMEN THAT TREATS SKIN CANCER (BASAL CELL CARCINOMA).

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
LOCALLY ADVANCED: DERMATOLOGIST OR ONCOLOGIST.
METASTATIC: ONCOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
VORICONAZOLE ORAL (VFEND)

**MEDICATION(S)**
VORICONAZOLE 200 MG TABLET, VORICONAZOLE 40 MG/ML SUSP, VORICONAZOLE 50 MG TABLET

**PA INDICATION INDICATOR**
3 - All Medically-Accepted Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Systemic fungal infection treatment: culture test confirms Aspergillosis, candidemia, deep-tissue candida infection, blastomycosis, scedosporium apiospermum, fusarium species. ABPA: current use of chronic oral corticosteroids. Candida infection of the esophagus, throat, mouth (esophageal or oropharyngeal candidiasis) after trial of fluconazole or there is a medical reason not to use fluconazole. Prophylaxis of asperilosis or candidiasis after a bone marrow or lung transplant and has a weakened defense system (immunosuppressed).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
BMT 6 MTHS LUNG TRANSPLANT: 3 MTHS ESOPH CANDIDIASIS: 1 MO ABPA: 4 MO SYSTEMIC TX: 12 MTHS

**OTHER CRITERIA**
N/A
VORINOSTAT (ZOLINZA)

MEDICATION(S)
ZOLINZA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTION
ONCOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
VORTIOXETINE (TRINTELLIX)

MEDICATION(S)
TRINTELLIX

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTED FAILURE ON 1 SSRI AND 1 SNRI

AGE RESTRICTION
NOT APPROVED IF LESS THAN 18 YEARS OF AGE

PRESCRIBER RESTRICTION
PSYCHIATRIST OR NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
VOXELOTOR (OXBRYTA)

**MEDICATION(S)**
OXBRYTA

**PA INDICATION INDICATOR**
1 - All FDA-Approved Indications

**OFF LABEL USES**
N/A

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Trial of or medical reason not to use hydroxyurea OR being added to current hydroxyurea therapy.

**AGE RESTRICTION**
12 years of age or older

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Plan year

**OTHER CRITERIA**
N/A
ZANUBRUTINIB (BRUKINSA)

MEDICATION(S)
BRUKINSA

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Mantle Cell Lymphoma (MCL): prior treatment of MCL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Plan year

OTHER CRITERIA
N/A
MEDICATION(S)
ZALTRAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MEDICAL REASON WHY PATIENT IS NOT ABLE TO USE FOLFIRI PLUS AVASTIN OR OTHER AVASTIN-CONTAINING REGIMEN TO TREAT COLON CANCER THAT HAS SPREAD TO OTHER AREAS OF THE BODY AND WHO HAVE FAILED THERAPY WITH OXALIPLATIN THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDED UNDER PART D IF COVERED BY PART B.
Part B vs D drugs

These drugs 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 drugs to make the determination.

Medication(s)

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>ROUTE</th>
<th>DOSE FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABELECET 100 MG/20 ML VIAL</td>
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<tr>
<td>ACETADOTE 200 MG/ML VIAL</td>
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<td>ACETYLCYSTEINE 10% VIAL</td>
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<td>ACETYLCYSTEINE 6 GRAM/30 ML VL</td>
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<td>AMINOSYN-PF 7% IV SOLUTION</td>
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<td>ARSENIC TRIOXIDE 12 MG/6 ML VL</td>
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<td>ASCENIV 10% VIAL</td>
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<td>ASPARLAS 3,750 UNIT/5 ML VIAL</td>
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<td>ASTHMANEFRIN RFILL 2.25% SOLN</td>
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<td>AVASTIN 400 MG/16 ML VIAL</td>
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<td>Beleodaq 500 mg Vial</td>
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<td>Belrapzo 100 mg/4 mL Vial</td>
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<td>Bentyl 10 mg/ml Ampul</td>
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<td>Betamethasone SP-AC 30 mg/5 mL</td>
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<tr>
<td>Bektis 300 mg/4 mL Ampule</td>
<td>Inhalation</td>
<td>Ampul-Neb</td>
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<td>Bleomycin Sulfate 30 Unit Vial</td>
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<td>Botox 100 Unit Vial</td>
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<td>Brovana 15 mcg/2 ml solution</td>
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<td>Calcitriol 0.5 mcg capsule</td>
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<td>Camptosar 300 mg/15 ml Vial</td>
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<td>Carboplatin 150 mg Vial</td>
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<td>Carnitor 1 gm/5 ml Vial</td>
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<td>Cellcept 200 mg/ml Oral Susp</td>
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<td>Chlorpromazine 25 mg/ml Amp</td>
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<td>MEDICATION NAME</td>
<td>ROUTE</td>
<td>DOSE FORM</td>
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<tr>
<td>CLOFARABINE 20 MG/20 ML VIAL</td>
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<td>INTRAVEN</td>
<td>PGGYBK BTL</td>
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<td>PIGGYBACK</td>
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<tr>
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