acitretin

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For prophylaxis of skin cancer in patients with previously treated skin cancers who have undergone an organ transplantation the request will be approved. For psoriasis: the patient has documented adequate trials and/or has another documented medical reason for not using at least 2 of the treatment options listed: topical steroids, Tazorac (tazarotene), methotrexate, and cyclosporine.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a dermatologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

actemra

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

actimmune

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

adefovir

Products Affected

- *adefovir dipivoxil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

adempas

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with PDE inhibitor or nitrate therapy
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification. For WHO Group I and IV, documentation of PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using PDE inhibitors or nitrates.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

afinitor

Products Affected

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- *everolimus oral tablet 2.5 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of members treatment history for relevant disease state. Provider attests that patient's complete blood count with differential, liver function, renal function, blood glucose and lipid profile will be monitored for the duration of therapy as indicated in compendia. Provider also attests that for patients who have subependymal giant cell astrocytoma (SEGA) or tuberous sclerosis complex (TSC)-associated partial seizure, whole blood trough concentration will be routinely monitored as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

alecensa

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that patient's liver function tests, heart rate and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

alpha-1 proteinase inhibitors

Products Affected

- ARALAST NP
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hereditary alpha1-antitrypsin deficiency as evident by pretreatment serum AAT levels below 11 micrometer/L and progressive FEV1 or FVC decline demonstrating symptomatic lung disease
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for an Alpha1-Proteinase Inhibitor (human) product other than Prolastin, the patient has a documented medical reason (such as trial, failure or contraindication) for not using Prolastin to treat their medical condition.
Indications	All Medically-accepted Indications.
Off Label Uses	

alunbrig

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that blood pressure, heart rate, serum glucose, creatine phosphokinase and lipase & amylase levels will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ambrisentan

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification and PAH Functional Class.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

anadrol

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

apokyn

Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

PA Criteria	Criteria Details
Exclusion Criteria	Apokyn (apomorphine hydrochloride) is contraindicated in concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. If diagnosis is Parkinsons, the patient has a documented trial and failure or intolerance to two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

arcalyst

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

aripiprazole long acting

Products Affected

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
- ARISTADA INITIO
- ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing one of these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ayvakit

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmation of PDGFRA mutation.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

balversa

Products Affected

- BALVERSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation has been provided indicating the patient has had an adequate trial of two or more of the following agents: glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a rheumatologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

benznidazole

Products Affected

- *benznidazole*

PA Criteria	Criteria Details
Exclusion Criteria	Patients who have used disulfiram within two weeks of initiation of benznidazole
Required Medical Information	Reviewer will verify available patient claim history to confirm that patient has not used disulfiram within two weeks prior to benznidazole initiation.
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized for 60 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

bosulif

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count, liver function tests and renal function will be monitored for the duration of therapy as indicated in compendia
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

braftovi

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmation of BRAF V600E or V600K mutation status with a FDA approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

brukinsa

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

c1 esterase inhibitor

Products Affected

- CINRYZE
- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation of either trial or a medical reason (e.g. intolerance or hypersensitivity) for not being able to use Danazol to manage their medical condition
Indications	All Medically-accepted Indications.
Off Label Uses	

cabometyx

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that urine protein levels and blood pressure will be monitored daily for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

calquence

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood cell count will be monitored prior to initiation and throughout duration of therapy as indicated in compendia
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hematologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cancidas

Products Affected

- *caspofungin acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of a consultation with an infectious disease specialist.
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

carbaglu

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cerdelga

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with undetermined CYP2D6 metabolizer status
Required Medical Information	Patient's CYP2D6 metabolizer status, as determined by an FDA approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For reauthorization, patient must have continued benefit with the use of agent.
Indications	All Medically-accepted Indications.
Off Label Uses	

cgrp antagonists

Products Affected

- AIMOVIG
- AIMOVIG (140 MG DOSE)
- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial request will be authorized for 6 months. Reauthorization until end of contract year.
Other Criteria	For a patient newly initiated on CGRP antagonists for migraine prophylaxis: Provider attests that patient has at least 4 migraine days per month or one or more severe migraines lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs). Patient must have documented trial and failure, intolerance or a medical reason for not being able to use two medications from the following classes (with each drug belonging to a different class): beta adrenergic blockers, anti-epileptics (topiramate, valproate or divalproex). For reauthorization a CGRP antagonist for migraine prophylaxis, patient must have experienced reduction of at least 1 headache day per month within the last month of the initial authorization period. For a patient newly initiated on Emgality for treatment of episodic cluster headache: Patient must have documented trial and failure (or a medical justification for not using) with verapamil for at least 4 weeks, at minimum effective doses. For reauthorization for Emgality for the treatment of episodic cluster headache, patient must have documented reduction in the frequency of headaches (clinical benefit).
Indications	All Medically-accepted Indications.
Off Label Uses	

cholbam

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hepatologist or gastroenterologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cimzia

Products Affected

- CIMZIA PREFILLED
- CIMZIA STARTER KIT
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

cometriq

Products Affected

- *cometriq (100 mg daily dose) oral kit 80 & 20 mg*
- *cometriq (140 mg daily dose) oral kit 3 x 20 mg & 80 mg*
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that blood pressure and urine protein will be monitored routinely for the duration of therapy as indicated in compendia
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

copiktra

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood counts will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

corlanor

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Exclusion Criteria	Blood pressure less than 90/50 mmHg
Required Medical Information	New starts for chronic heart failure must have all of the following: 1) chronic heart failure (NYHA II through IV), have LVEF of 35% or less 2) have sinus rhythm and have resting heart rate greater than or equal to 70 bpm 3) blood pressure greater than or equal to 90/50 mmHg and 4) Tried or is currently receiving beta blocker unless the patient has a contraindication to the use of beta blocker therapy.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Continuation of therapy for chronic heart failure: decreased number of hospitalizations due to acute heart failure while using Corlanor.
Indications	All Medically-accepted Indications.
Off Label Uses	

cosentyx

Products Affected

- COSENTYX
- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SENSOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

cotellic

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that LVEF, SCr, CPK, LFTs have been assessed, and dermatologic and ophthalmologic evaluations have been performed prior to initiation of therapy, and will be routinely assessed throughout the duration of therapy as indicated in compendia. Additionally, for appropriate indications confirmation of BRAF V600K or V600E mutation status with an FDA approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cubicin

Products Affected

- *daptomycin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of a consultation with an infectious disease specialist.
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

cystagon

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

dalfampiridine er

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure.
Required Medical Information	If diagnosis is RRMS, documentation has been provided that member is ambulatory (able to walk at least 25 feet), has a documented walking impairment, and is currently being treated with a disease modifying agent (e.g. immunomodulator, interferon, etc) or has a medical reason why member is unable to use a disease modifying agent for their condition. For all other types of MS, only documentation that member is ambulatory with a documented walking impairment is required.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For re-authorization, member must experience improvement in walking due to use of Ampyra
Indications	All Medically-accepted Indications.
Off Label Uses	

daurismo

Products Affected

- DAURISMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that ECG and blood chemistries including electrolytes will be completed prior to initiation of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

deferasirox

Products Affected

- *deferasirox*
- *deferasirox granules*

PA Criteria	Criteria Details
Exclusion Criteria	Patients with GFR less than 40 mL/min/1.73 m(2), patients with platelet counts less than 50,000/mm3
Required Medical Information	For diagnosis of chronic iron overload due to transfusions: laboratory result within 30 days of request for serum ferritin concentration is greater than 1000 mcg/L, platelet count, GFR greater than 40 mL/min/1.73 m(2). For diagnosis of chronic iron overload in nontransfusion-dependent thalassemia syndromes: laboratory results with 30 days of request for serum ferritin concentration is greater than 300mcg/L, platelet counts, GFR greater than 40 mL/min/1.73 m(2).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

demser

Products Affected

- DEMSER
- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of one of the following: 1)Concurrent use of alpha adrenergic blockers 2) medical reason for being unable to use an alpha adrenergic blocker OR 3)patient is not a candidate for surgical resection and requires long term treatment with Demser
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

depen

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

depo-provera

Products Affected

- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a gynecologist, family practice or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

DIACOMIT

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count will be completed prior to initiation and throughout duration of therapy as indicated in compendia
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

dificid

Products Affected

- DIFICID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 10 days.
Other Criteria	Documentation of prior use, or a medical reason for being unable to use oral vancomycin for current infection.
Indications	All Medically-accepted Indications.
Off Label Uses	

doptelet

Products Affected

- DOPTELET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For thrombocytopenia with CLD getting procedure: 5 days. For chronic ITP: remainder of contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

drizalma

Products Affected

- DRIZALMA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that generic duloxetine capsules cannot be used.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

dupixent

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented trial and failure or medical reason (e.g. very large surface area affected by atopic dermatitis) for not using the following therapies: 1) topical tacrolimus or pimecrolimus and 2) Eucrisa. For diagnosis of asthma: documentation that symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months or medical reason has been provided indicating why a patient is not able to utilize a high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) to treat their medical condition. For treatment of chronic rhinosinusitis with nasal polypsis: trial, failure, intolerance, or medical reason for not being able to use nasal corticosteroids.
Indications	All Medically-accepted Indications.
Off Label Uses	

egrifta

Products Affected

- EGRIFTA
- *egrifta sv*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of active antiretroviral therapy for at least 8 weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

enbrel

Products Affected

- ENBREL MINI
- *enbrel subcutaneous solution 25 mg/0.5ml*
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using the following if applicable for submitted diagnosis: 1) For Rheumatoid Arthritis, Psoriatic Arthritis, or Juvenile Idiopathic Arthritis: one DMARD (e.g. methotrexate, sulfasalazine, generic leflunomide (Arava), etc.), 2) For Ankylosing Spondylitis: two nonsteroidal anti-inflammatory drugs (NSAIDS), 3) For Plaque Psoriasis one of the following: topical steroids, topical calcipotriene, Tazorac (tazorotene), Methotrexate, UVB phototherapy and/or PUVA therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

endari

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation that patient has had two or more painful sickle cell crises within the past 12 months and that they have been taking hydroxyurea for the past three months or longer.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

epidiolex

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function tests and bilirubin levels will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

eraxis

Products Affected

- ERAXIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	Request will be approved for 42 days of treatment per request.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

erivedge

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or dermatologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

erleada

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For appropriate indication(s) patient must have history of bilateral orchiectomy or must be concurrently using Erleada with gonadotropin-releasing hormone (GnRH).
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or an urologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

erlotinib

Products Affected

- *erlotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function tests and renal function test will be completed for the duration of therapy as indicated in compendia. For appropriate indications, confirmation of mutation as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ertapenem

Products Affected

- *ertapenem sodium*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

erythropoetin stimulating agents

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 150 MCG/0.75ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE
- EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML
- PROCRIT
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Laboratory results within 30 days of request: Hemoglobin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	For initial therapy, the Hgb must be less than 10g/dL for all indications or within compendia range for treatment of the requested medical condition. If the request is for Aranesp, the provider submitted a documented medical reason (i.e. intolerance, contraindication, hypersensitvity) why they are unable to use Epogen, Procrit or Retacrit. For re-authorization, Hgb must not exceed 10g/dL(cancer), 12g/dL(zidovudine-treated HIV patients), 13 g/dL(Elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).
Indications	All Medically-accepted Indications.
Off Label Uses	

esbriet

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 801 MG
- *esbriet oral tablet 267 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

eucrisa

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a dermatologist, immunologist or an allergist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documented trial and failure or medical reason (e.g. intolerance or hypersensitivity) for not using the following therapies: Topical tacrolimus or pimecroliumus.
Indications	All Medically-accepted Indications.
Off Label Uses	

evrysdi

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Initial request will be authorized for 6 months. Reauthorization until end of contract year.
Other Criteria	For initial approval, all of the following must be included: 1) Documentation of genetic testing confirming diagnosis AND 2) Documentation of baseline motor function or motor milestone achievement [e.g. CHOP Infant Test of Neuromuscular Disorders (CHOP-INTEND) or Hammersmith Infant Neurological Examination (HINE) for Type 1 or Hammersmith Functional Motor Scale Expanded Scores (HFMSE) for Type II and Type III, or 6 minute walk test in subjects able to walk]. For reauthorization, documentation of clinical response has been submitted (e.g. improvement in motor function/motor milestone achievement scores using CHOP-INTEND or HFMSE, 6 minute walk test or HINE improvement in more categories of motor milestones than worsening, patient remains permanent ventilation free if no prior ventilator support).
Indications	All Medically-accepted Indications.
Off Label Uses	

farydak

Products Affected

- FARYDAK ORAL CAPSULE 10 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior treatment history for related indications.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

fentanyl citrate oral transmucosal

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	Patient is currently receiving long-acting opioid therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

ferriprox

Products Affected

- *deferiprone*
- FERRIPROX ORAL TABLET
- FERRIPROX TWICE-A-DAY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, documentation of the patient's serum ferritin level above 2,500 mcg/L and absolute neutrophil count (ANC) greater than 1.5x10^9/L within 30 days of request.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For continuation of therapy, approve if the patient is benefiting from therapy as confirmed by the prescribing provider.
Indications	All Medically-accepted Indications.
Off Label Uses	

fintepla

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	The request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

firdapse

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	History of seizures.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

forteo

Products Affected

- *forteo subcutaneous solution pen-injector*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation showing patient falls into one of the following categories:Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture.Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent. Male greater than or equal to 65 years of age with T-score of -2.5 or less. Male less than 65 years of age with T-score of -2.5 or less and 2 or more risk factors for fractures or previous osteoporotic fracture.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable:The patient has a documented treatment failure or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not utilizing an oral bisphosphonate to manage their medical condition AND The therapy does not exceed the therapy maximum of 2 years.
Indications	All Medically-accepted Indications.
Off Label Uses	

galafold

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

gattex

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Provider is a gastroenterologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

gavreto

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

gilotrif

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function monitoring will be completed for the duration of therapy as indicated in compendia. For appropriate indications, documentation of the FDA-approved test results confirming EGFR mutation status were submitted.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

gleostine

Products Affected

- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count with differential will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

gnrh agonists

Products Affected

- ELIGARD
- FIRMAGON
- FIRMAGON (240 MG DOSE)
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 7.5 MG
- LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED)
- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for the treatment of prostate cancer and if the request is for any other GnRH agonist other than Eligard, the patient must have a documented treatment failure after receiving an trial of Eligard and/or has another documented medical reason for not utilizing Eligard to treat their prostate cancer.
Indications	All Medically-accepted Indications.
Off Label Uses	

gocovri

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial request: documented trial and failure or medical reason for not using generic amantadine.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Initial request will be authorized for 3 months. Reauthorization until end of contract year.
Other Criteria	Re-authorization: confirmation of improvement in levodopa-induced dyskinesia due to use of Gocovri
Indications	All Medically-accepted Indications.
Off Label Uses	

growth hormones

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria for new starts for growth hormone deficiency: Growth Hormone Stimulation Test results, Insulin Growth Factor 1 level, bone age testing, height, and weight. All other medically accepted uses can be approved.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an endocrinologist or nephrologist
Coverage Duration	Initial request will be authorized for 6 months. Reauthorization until end of contract year.
Other Criteria	Criteria for continuation of therapy for growth hormone deficiency: medical records showing positive response to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	

h. p. acthar

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, ophthalmic disease and respiratory diseases, documentation was submitted indicating trials and/or a documented medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing high-dose parenteral corticosteroids to manage their medical condition.
Age Restrictions	
Prescriber Restrictions	For Infantile spasms and MS exacerbation: neurologist. For Rheumatic Disorders and Collagen Diseases: rheumatologist. For Dermatologic: dermatologist. For Allergic state: allergist, immunologist. For Ophthalmic disease: optometrist, ophthalmologist. Respiratory diseases: pulmonologist. For Edematous state: nephrologist, rheumatologist.
Coverage Duration	MS exacerbation: 1 month. Other conditions: initial for 3 months and reauth end of contract year.
Other Criteria	Reauthorization Criteria: 1) For continuation of therapy for MS exacerbation, documentation of symptom improvement and confirmation that member is currently maintained on multiple sclerosis drugs such as Copaxone, Avonex, or Aubagio. 2) For all other conditions, documented evidence of disease response to treatment as indicated by improvement in symptoms.
Indications	All Medically-accepted Indications.
Off Label Uses	

hetlioz

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Provider is a sleep specialist or neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication

Products Affected

- *chlorzoxazone oral tablet 500 mg*
- *clemastine fumarate oral tablet 2.68 mg*
- CYCLOBENZAPRINE COMFORT PAC
- CYCLOTENS REFILL PAK
- CYCLOTENS STARTER PAK
- *cyproheptadine hcl oral*
- *dexmethylphenidate hcl*
- *dexmethylphenidate hcl er*
- *dipyridamole oral*
- *disopyramide phosphate oral*
- *ergoloid mesylates oral*
- *glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*
- *guanfacine hcl oral*
- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet 25 mg, 50 mg*
- *hydroxyzine pamoate oral*
- *indomethacin er*
- *indomethacin oral capsule 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 625 mg/5ml*
- *meperidine hcl oral solution*
- *meperidine hcl oral tablet*
- *methocarbamol oral*
- *methyldopa oral*
- *methyldopa-hydrochlorothiazide*
- *methylphenidate hcl er (cd)*
- *methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 30 mg, 40 mg, 60 mg*
- *methylphenidate hcl er (xr)*
- *methylphenidate hcl er oral tablet extended release 10 mg, 18 mg, 20 mg, 27 mg, 36 mg, 54 mg*
- *methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 36 mg, 54 mg*
- *methylphenidate hcl oral*
- *nifedipine oral*
- NORPACE CR
- *orphenadrine citrate er*
- *pentazocine-naloxone hcl*
- *promethazine hcl oral*
- *promethazine hcl rectal suppository 12.5 mg, 25 mg*
- *promethazine vc*
- *promethazine vc plain oral solution*
- *promethazine-phenylephrine*
- PROMETHEGAN RECTAL SUPPOSITORY 50 MG
- *trihexyphenidyl hcl*
- *trimethobenzamide hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.

PA Criteria	Criteria Details
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication - protected class drugs

Products Affected

- *amitriptyline hcl oral*
- *clomipramine hcl oral*
- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*
- *imipramine hcl oral*
- *imipramine pamoate*
- *megestrol acetate oral tablet*
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- *perphenazine-amitriptyline*
- *thioridazine hcl oral*
- *trimipramine maleate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication, butalbital

Products Affected

- ASCOMP-CODEINE
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral capsule 50-325-40 mg*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-asa-caffeine*
- *butalbital-aspirin-caffeine oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication. Additionally, documentation was submitted of adequate trials and/or medical reason (e.g. intolerance or hypersensitivity) for not utilizing this therapy to manage their medical condition: one formulary oral NSAID
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication, digoxin

Products Affected

- DIGITEK ORAL TABLET 250 MCG
- DIGOX ORAL TABLET 250 MCG
- *digoxin oral solution*
- *digoxin oral tablet 250 mcg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: Patient must have documented trial and failure to doses up to 0.125mg per day OR the prescriber has documented the indication for the use of doses greater than 0.125mg per day. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication, short term muscle relaxant

Products Affected

- *carisoprodol oral*
- *carisoprodol-aspirin-codeine*
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Initial request will be authorized for 30 days. Reauthorizaton will be for 90 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

high risk medication, sleep agents

Products Affected

- *eszopiclone*
- *zolpidem tartrate er*
- *zolpidem tartrate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication. Additionally, documentation was submitted of adequate trials and/or medical reason (e.g. intolerance or hypersensitivity) for not utilizing this therapy to manage their medical condition: zolpidem immediate release.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

humira

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PS/UV/ADOL HS START
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For Hidradenitis suppurativa: confirmation of Hurley Stage II or III disease. Trial and failure or medical reason for not using the following if applicable for submitted diagnosis: 1) For Rheumatoid Arthritis, Psoriatic Arthritis, or Juvenile Idiopathic Arthritis: one DMARD (e.g. methotrexate, sulfasalazine, generic leflunomide (Arava), etc.), 2) For Ankylosing Spondylitis: two nonsteroidal anti-inflammatory drugs (NSAIDS), 3) For Plaque Psoriasis: one of the following: moderate to high potency topical steroids, topical calcipotriene, Tazorac (tazorotene), Methotrexate, UVB phototherapy and/or PUVA therapy. 4) For Crohns Disease and Ulcerative Colitis: one conventional oral therapy (e.g. azathioprine, sulfasalazine, prednisone, mesalamine products). 5) For Non-infectious Uveitis: one ophthalmic corticosteroid.
Indications	All Medically-accepted Indications.
Off Label Uses	

ibrance

Products Affected

- IBRANCE ORAL CAPSULE
- *ibrance oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of breast cancer, documentation of specific type of cancer (e.g. HR-positive, HER2-negative). Provider attests that complete blood count with differential test will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ICATIBANT

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

iclusig

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function tests, serum lipase, cardiac function and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

idhifa

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count and serum potassium, phosphate, calcium and uric acid levels will be monitored throughout the duration of the therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

imatinib

Products Affected

- *imatinib mesylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count with differential and liver function tests will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

imbruvica

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count with differential will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist, hematologist or transplant specialist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

increlex

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

inlyta

Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function tests, thyroid function, blood pressure and urinalysis will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

inqovi

Products Affected

- *inqovi*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

INREBIC

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that thiamine levels will be assessed prior to initiation and monitored for the duration of therapy as indicated in compendia
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

intron-a

Products Affected

- INTRON A

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

iressa

Products Affected

- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function monitoring will be completed for the duration of therapy as indicated in compendia. For appropriate indications, documentation of the FDA-approved test results confirming mutation were submitted.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

jakafi

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count and lipid profile monitoring will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Patients with moderate or severe hepatic impairment (Child- Pugh B or C) or active liver disease.
Required Medical Information	Documentation of treatment history, trial and failure after three months with Repatha or has a documented medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing Repatha to manage their condition. In addition, a fasting lipid panel report with abnormal LDL cholesterol results (over 70mg/dL) and baseline LFTs and bilirubin, along with patient's Child Pugh Score are required within 90 days of request.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist, specialist in treatment of lipid disorders or endocrinologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

jynarque

Products Affected

- JYNARQUE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that transaminases and bilirubin will be monitored prior to initiation and throughout duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a nephrologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

kalydeco

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi
Required Medical Information	Documentation of cystic fibrosis mutation.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

keveyis

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial request: 1) Provider attests that serum potassium and serum bicarbonate will be monitored for the duration of therapy as indicated in compendia 2) Documentation has been provided that the patient has tried and failed or has a documented medical reason for not utilizing acetazolamide.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a geneticist, neurologist, or endocrinologist.
Coverage Duration	Initial request will be authorized for 2 months. Reauthorization until end of contract year.
Other Criteria	Reauthorization requires documentation of clinical improvement with therapy. Provider attests that serum potassium and serum bicarbonate will be monitored for the duration of therapy as indicated in compendia
Indications	All Medically-accepted Indications.
Off Label Uses	

kineret

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

kisqali

Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KISQALI FEMARA(200 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count with differential, liver function test, serum electrolytes and ECG monitoring will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

korlym

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	For all members patient must not be currently on simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quididine, sirolimus, and tacrolimus.
Required Medical Information	Reviewer will verify available claim history to confirm member is not taking simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quididine, sirolimus or tacrolimus concurrently with Korylm.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

koselugo

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or neurologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

kuvan

Products Affected

- KUVAN
- *sapropterin dihydrochloride*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy, documentation of elevated baseline phenylalanine levels
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial request will be authorized for 3 months. Reauthorization until end of contract year.
Other Criteria	Reauthorization criteria: prescriber has confirmed improvement in phenylalanine levels from baseline
Indications	All Medically-accepted Indications.
Off Label Uses	

kynmobi

Products Affected

- *kynmobi*

PA Criteria	Criteria Details
Exclusion Criteria	Kynmobi (apomorphine hydrochloride) is contraindicated in concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. If diagnosis is Parkinsons, the patient has a documented trial and failure or intolerance to two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

lazanda

Products Affected

- LAZANDA NASAL SOLUTION 100 MCG/ACT, 300 MCG/ACT, 400 MCG/ACT

PA Criteria	Criteria Details
Exclusion Criteria	This product must not be used in opioid intolerant patients and contraindicated in the management of acute or postoperative pain.
Required Medical Information	The patient is currently receiving and tolerant to opioid therapy for chronic pain. Patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrolled nausea/vomiting. Patient must have documented trial and failure or intolerance to fentanyl citrate oral transmucosal.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

lenvima

Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function, renal function, thyroid function will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

lonsurf

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood count including differential and absolute neutrophil count will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

lorbrena

Products Affected

- LORBRENA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that ECG, serum cholesterol and triglycerides will be completed prior to initiation of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

lucemyra

Products Affected

- LUCEMYRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	Patient must have documented trial and failure or intolerance to clonidine. Reauthorization criteria: chart notes that show positive response to prior treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	

lynparza

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of patient's treatment history for related conditions.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

mavyret

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Labs within 3 months of request: ALT/AST, detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 8-16 weeks as per AASLD-IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD-IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

mekinist

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC, liver function and LVEF will be monitored for the duration of therapy as indicated in compendia. For appropriate indications, documentation of FDA approved mutation testing was submitted confirming the presence of BRAF V600E or V600K mutations.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

mektovi

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function test and LVEF will be completed for the duration of therapy as indicated in compendia. Additionally, confirmation of BRAF V600E or V600K mutation status with a FDA approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

methyltestosterone

Products Affected

- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

multiple sclerosis agents

Products Affected

- AUBAGIO
- BAFIERTAM
- BETASERON SUBCUTANEOUS KIT
- *dimethyl fumarate oral*
- *dimethyl fumarate starter pack*
- EXTAVIA SUBCUTANEOUS KIT
- GILENYA ORAL CAPSULE 0.5 MG
- *glatiramer acetate*
- GLATOPA
- KESIMPTA
- MAYZENT
- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TECFIDERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for glatiramer, glatopa, or Aubagio, the request will be approved. If the medication is not for glatiramer, glaptopa, or Aubagio, will require documentation showing trial of two of the following agents: Aubagio, glatiramer, or glatopa OR the patient has another documented medical reason (intolerance, hypersensitivity, etc) for not taking any of these therapies to manage their medical condition.
Indications	All Medically-accepted Indications.
Off Label Uses	

mycamine

Products Affected

- *micafungin sodium*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 12 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

natpara

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of serum calcium greater than 7.5 mg/dL and vitamin D level (within 30 days of request).
Age Restrictions	
Prescriber Restrictions	Provider is an endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nerlynx

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber attests that liver function tests will be assessed prior to initiation and throughout the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nexavar

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nexletol

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	For initial requests ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C) 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin 3) Member has tried and failed ezetimibe at a maximum tolerated dose or documentation has been provided that the patient is not able to tolerate ezetimibeAND 4) Member will continue on maximum tolerated statin dose and ezetimibe dose while receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe.In addition to the initial criteria above if the initial request is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm AND 2) Member must have a fasting LDL-C greater than or equal to 70 mg/dL. For reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline) AND 2) Member will continue on maximum tolerated statin and ezetimibe dose while

PA Criteria	Criteria Details
	receiving Nexletol or documentation has been provided that the member is not able to tolerate a statin and/or ezetimibe.
Indications	All Medically-accepted Indications.
Off Label Uses	

nexlizet

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	For initial requests ALL of the following must be provided: 1) Documentation of baseline low density lipoprotein cholesterol (LDL-C), 2) Member has tried and failed a high-intensity statin (i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg) at maximum tolerated dose for 3 months via claim history or chart notes OR documentation has been provided that the member is not able to tolerate a statin, AND 3) Member will continue on maximum tolerated statin dose while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin. In addition to the initial criteria above if the initial request is for the diagnosis of hyperlipidemia and atherosclerotic cardiovascular disease (ASCVD), the following are required: 1) Documentation of history of least one of the following: myocardial infarction or acute coronary syndrome, stroke or transient ischemic attack, coronary artery disease with stable angina, coronary or other arterial revascularization, peripheral vascular disease, or aortic aneurysm, AND 2) Member must have a fasting LDL-C greater than or equal to 70 mg/dL. For reauthorization requests for all indications: 1) Documentation provided that the member has obtained clinical benefit from medication (e.g. LDL-C lowering from baseline), AND 2) Member will continue on maximum tolerated statin while receiving Nexlizet or documentation has been provided that the member is not able to tolerate a statin.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	

ninlaro

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function and platelet counts will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nitisinone

Products Affected

- *nitisinone*
- ORFADIN ORAL CAPSULE 20 MG
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nityr

Products Affected

- NITYR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

noctiva

Products Affected

- NOCTIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that eGFR and serum sodium will be monitored throughout the duration of the therapy, and that the patient does not have baseline hyponatremia or primary nocturnal enuresis.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a urologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For patients newly starting on Noctiva: For respective indications, patient must have shown either a lack of benefit during trial of one of the following medications, or is experiencing nocturia unrelated to any of the following etiologies. Nocturia secondary to lower urinary tract symptoms or benign prostate enlargement: trial of alpha adrenergic antagonists (e.g. tamsulosin, alfuzosin). Nocturia secondary to benign prostate hyperplasia: trial of alpha adrenergic antagonist and 5-alpha reductase inhibitor (e.g. finasteride). Nocturia due to nocturnal polyuria: trial of bumetanide during daytime. Nocturia secondary to overactive bladder: trial of an antimuscarinic agent (e.g. oxybutynin).
Indications	All Medically-accepted Indications.
Off Label Uses	

non-amphetamine central nervous system agents

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

noxafil

Products Affected

- NOXAFIL ORAL SUSPENSION
- *posaconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	28 days for oropharyngeal candidiasis, end of contract year for other indications
Other Criteria	For treatment of oropharyngeal candidiasis, there must be documentation of either at least a one week trial or a medical reason (e.g. intolerance, known resistance, hypersensitivity) for not being able to use one of the following agents: fluconazole or itraconazole
Indications	All Medically-accepted Indications.
Off Label Uses	

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nucala

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist, immunologist, or allergist
Coverage Duration	Initial request will be approved for 6 months. All subsequent requests will be approved for 1 year
Other Criteria	Initial Authorization for severe asthma: 1. Documentation has been provided with blood eosinophil count greater thanor equal to 150 cells per microliter within 6 weeks or 300 cells per microliter within 12 months. AND 2. Documentation has been provided indicating patient still is having symptoms or equal to or greater than 2 exacerbations in the previous 12 months requiring additional medical treatment, (e.g. oral systemic steroids, emergency room visits, hospital admissions) while compliant on a high-dose inhaled corticosteroid with a long-acting B2 agonist with or without a leukotriene receptor antagonist OR theophylline. If the patient has not utilized these therapies, a documented medical reason must be provided why patient is unable to do so. Initial authorization for eosinophilic granulomatosis with polyangiitis (EGPA): Trial and failure or intolerance to one of the following medications: cyclophosphamide or methotrexate. Re-Authorization for all indications: Documentation submitted indicates the member has clinically benefited from the medication (FEV1, reduced exacerbations, eosinophil count, etc.)
Indications	All Medically-accepted Indications.
Off Label Uses	

nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

nuplazid

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG, 17 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ocaliva

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	Members with complete biliary obstruction.
Required Medical Information	Initial for primary biliary cholagnitis (PBC): 1) member has failed at least a 12 month trial of ursodiol, or a medical reason was submitted (e.g. intolerance, hypersensitivity) that the member is unable to tolerate ursodiol, 2) lab results for baseline ALT/AST, alkaline phosphatase (ALP), bilirubin, and lipid profile within 90 days of request. Reauthorization for primary biliary cholangitis (PBC): repeat ALT/AST, ALP, bilirubin and lipid profile within 30 days of request with improvement in at least ALP and/or bilirubin values.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

octreotide acetate

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*
- SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If criteria are met, a prior authorization for the generic octreotide will be approved. Otherwise, documentation showing an adverse event or inadequate response associated with use of the generic agent must be submitted for review.
Indications	All Medically-accepted Indications.
Off Label Uses	

odomzo

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that serum creatine kinase levels and renal function will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ofev

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If diagnosis is idiopathic pulmonary fibrosis, member must have documented trial of Esbriet or provide medical justification (e.g. intolerance or hypersensitivity) for not utilizing Esbriet. If diagnosis is for systemic sclerosis-associated interstitial lung disease (SSc-ILD), the member must have documented trial and failure or intolerance to mycophenolate mofetil or cyclophosphamide
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

onureg

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

oral antipsychotics

Products Affected

- *caplyta*
- FANAPT
- FANAPT TITRATION PACK
- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of schizophrenia and manic or mixed episodes associated with bipolar l disorder, the patient must have documented trial and failure or intolerance to one formulary generic antipsychotics (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone) AND Saphris. For major depressive disorder associated with bipolar l disorder, the patient must have documented trial and failure or intolerance to two formulary generic antipsychotics (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

orencia

Products Affected

- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

orilissa

Products Affected

- ORILISSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an OB/GYN.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documentation of trial and failure, intolerance, or contraindication of at least two of following classes used concurrently for the treatment of endometriosis: analgesic pain reliever (e.g. NSAIDs, COX-2 inhibitors) AND either combined estrogen-progestin oral contraceptive, progestin (e.g. medroxyprogesterone acetate, norethindrone), gonadotropin-releasing hormone (GnRH) agonists (e.g. Lupron Depot), OR danazol. For reauthorization, patient must have continued benefit with use of agent.
Indications	All Medically-accepted Indications.
Off Label Uses	

orkambi

Products Affected

- ORKAMBI ORAL PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco
Required Medical Information	Documentation of cystic fibrosis mutation.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an pulmonologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

otezla

Products Affected

- OTEZLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications. If the request is for the indication of treatment of Behcet's disease, the request will be approved.
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the request is for the indication of treatment of Behcet's disease, the request will be approved. If the request is for plaque psoriasis or psoriatic arthritis, patient must have trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept).
Indications	All Medically-accepted Indications.
Off Label Uses	

oxbryta

Products Affected

- OXBRYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Presciber must be a hematologist
Coverage Duration	Initial request will be approved for 6 months. Reauthorization will be approved for 12 months
Other Criteria	Initial Authorization: Baseline labs have been submitted for the following: Hemoglobin (Hb), Indirect bilirubin, Reticulocytes. Documentation was provided that the member has had 1 or more pain crises in the last 12 months. Member has a baseline Hb level less than 10.5 g/dL. Documentation was provided that the member has been taking hydroxyurea at the maximum tolerated dose (or a medical reason was provided why the patient is unable to use hydroxyurea) Reauthorization: Documentation submitted indicates clinical benefit at 6 months from initiation, and continued clinical benefit at subsequent 12-month intervals defined as the following: Documentation of one of the following: Hb increase from baseline (at 6 months from initiation) or maintenance of such Hb increase (at 12-month intervals thereafter) Or documentation of reduced number of vaso-occlusive/pain crises since Oxbryta was started Or documentation of one of the following: Decrease in indirect bilirubin from baseline Or decrease in percentage of reticulocytes from baseline
Indications	All Medically-accepted Indications.
Off Label Uses	

oxervate

Products Affected

- *oxervate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an ophthalmologist.
Coverage Duration	The request will be authorized for 8 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

oxsoralen ultra

Products Affected

- *methoxsalen rapid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial and failure or intolerance to methotrexate.
Indications	All Medically-accepted Indications.
Off Label Uses	

oxycodone er

Products Affected

- *oxycodone hcl er oral tablet er 12 hour abuse-deterrent*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	NEW START: Patient must meet ALL of the following criteria: (1) patient has a documented trial and failure or intolerance to two formulary long-acting pain medications (2) member is not being treated for substance abuse (3) if member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber should provide attestation of an intent to monitor side effects AND provide documentation that patient counseling has and will continue to take place outlining the risks and potential side effects of concurrent use of benzodiazepines, opioids and/or muscle relaxants AND (4) member has documented history of receiving a non-opioid analgesic or immediate-release opioid. CONTINUING THERAPY: Documentation of ALL of the following : (1)member's pain has been assessed within the last 3 months (2) member has demonstrated improved functioning on current medication regimen (3) member is not being treated for substance abuse AND (4) if member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber should provide attestation of an intent to monitor side effects AND provide documentation that patient counseling has and will continue to take place outlining the risks and potential side effects of concurrent use of benzodiazepines, opioids and/or muscle relaxants.

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	

paliperidone

Products Affected

- *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For the diagnosis of schizophrenia: the patient must have documented failure or intolerance to a formulary second generation atypical antipsychotic
Indications	All Medically-accepted Indications.
Off Label Uses	

paliperidone long acting

Products Affected

- INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML
- INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.875ML, 410 MG/1.315ML, 546 MG/1.75ML, 819 MG/2.625ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral risperidone or oral paliperidone without any clinically significant side effects. For requests for Invega Trinza, the member has documented treatment with Invega Sustenna for at least 4 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

peginterferon

Products Affected

- PEGASYS PROCLICK SUBCUTANEOUS SOLUTION 180 MCG/0.5ML
- PEGASYS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Hepatitis C: Labs within 3 months of request: ALT/AST, and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. For Hepatitis B: Labs within 3 months of request: ALT/AST. In addition, documentation of HBeAg status is required.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, infectious disease doctor or transplant specialist.
Coverage Duration	Request will be authorized for up to 48 weeks as defined by compendia.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

pemazyre

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

pentamidine solution for injection

Products Affected

- *pentamidine isethionate injection*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

perseris

Products Affected

- PERSERIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

phenoxybenzamine

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

piqray

Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

pomalyst

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential and liver function test will be completed for the duration of therapy as indicated in compendia. For appropriate indications, documentation of trial of Revlimid and a proteosome inhibitor prior to initiating Pomalyst.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

praluent

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist, endocrinologist, or a specialist in treatment of lipid disorders.
Coverage Duration	Initial: authorized for 4 months. Reauthorization: authorized until the end of the contract year.
Other Criteria	For primary hyperlipidemia and ALL diagnoses for initial approval:documentation (copy of dated lab results required) of two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with two high potency statins (atorvastatin and rosuvastatin) or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies. If patient experiences intolerance, documentation that patient has undergone a trial of statin re-challenge with maximally tolerated dose of statins with continued abnormal LDL cholesterol results (above 70mg/dL) or with documented return of side effects. If diagnosis is familial hypercholesterolemia (FH), additional documentation has been provided including TWO of the following: 1) genetic testing (copy of dated lab results required) confirming FH diagnosis OR 2) clinical manifestations of FH such as xanthomas or inflamed tendons OR 3) a clinical diagnosis of FH using the Dutch Lipid Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-Broome Diagnostic criteria (total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree parent, sibling or child) or second-degree relative (grandparent, uncle or aunt). If diagnosis is ASCVD, additional documentation has been provided that includes history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other

PA Criteria	Criteria Details
	arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. For ALL diagnoses for initial reauthorization: patient has had repeat LDL cholesterol lab (copy of dated lab result required) showing improvement in LDL from initial request. For all other reauthorization requests, LDL cholesterol lab (copy of dated lab result required) was submitted with request.
Indications	All Medically-accepted Indications.
Off Label Uses	

pretomanid

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	MDR-TB that is not treatment-intolerant or nonresponsive to standard therapy
Required Medical Information	Documentation of use in combination with bedaquiline and linezolid. Laboratory confirmed pulmonary MDR-TB resistant to isoniazid and rifampin
Age Restrictions	
Prescriber Restrictions	Documentation of a consultation with an infectious disease specialist
Coverage Duration	Request will be authorized for 26 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

prevymis

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that serum creatinine and renal function will be monitored prior to initiation and throughout duration of therapy as indicated in compendia
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hematologist, oncologist, infectious disease, or transplant specialist.
Coverage Duration	Request will be authorized for 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

prolia

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of osteoporosis: Documentation showing patient falls into one of the following categories: Postmenopausal woman or a male patient who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than - 2.5) or who has had an osteoporotic fracture. Postmenopausal woman or man with a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability greater than 3% or a 10 year major osteoporosis-related fracture probability greater than 20% based on the US-adapted WHO absolute fracture risk model.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable: The patient has a documented treatment failure after receiving a trial (including dates of treatment at maximum recommended doses of therapy) or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not utilizing an oral bisphosphonate to manage their medical condition.
Indications	All Medically-accepted Indications.
Off Label Uses	

promacta

Products Affected

- PROMACTA ORAL PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that all liver function tests, as well as CBC with differential will be monitored prior to initiation and throughout the therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

qinlock

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

regranex

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 20 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

relistor

Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 8 MG/0.4ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial and failure or intolerance to 1) Amitiza, and 2) lactulose or polyethylene glycol. Additionally, for constipation caused by opioids that are used for chronic, non-cancer pain, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection.
Indications	All Medically-accepted Indications.
Off Label Uses	

repatha

Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a cardiologist or a specialist in treatment of lipid disorders.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	For primary hyperlipidemia and ALL diagnoses for initial approval:documentation (copy of dated lab results required) of two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with two high potency statins (atorvastatin and rosuvastatin) or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies. Intolerance requires chart notes or supporting labs that confirm intolerable statin related adverse effects including elevated LFTs, rhabdomyolysis, intolerable myalgia or myopathy or myositis. If patient experiences intolerance, patient has undergone a trial of statin re-challenge with maximally tolerated dose of statins for a minimum of 3 months with continued abnormal LDL cholesterol results (above 70mg/dL) or with documented return of side effects. If diagnosis is familial hypercholesterolemia (FH), additional documentation has been provided including TWO of the following: 1) genetic testing (copy of dated lab results required) confirming FH diagnosis OR 2) evidence of FH in first or second degree relatives with history of high levels of total cholesterol, tendon xanthoma, or sudden cardiac death or premature clinical atherosclerotic cardiovascular disease (ASCVD) before 55 years in men and 60 years in women OR 3) clinical manifestations of FH such as xanthomas or inflamed tendons OR 4) a clinical diagnosis of FH using the Dutch Lipid Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-Broome Diagnostic criteria

PA Criteria	Criteria Details
	(total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree parent, sibling or child) or second-degree relative (grandparent, uncle or aunt). If diagnosis is ASCVD, additional documentation has been provided that includes history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. For ALL diagnoses for initial reauthorization: patient has repeat LDL cholesterol lab (copy of dated lab result required) showing improvement in LDL from initial request. For all other reauthorization requests patient had repeat LDL cholesterol lab (copy of dated lab result required) was submitted with request.
Indications	All Medically-accepted Indications.
Off Label Uses	

retevmo

Products Affected

- RETEVMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

revatio oral

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

revlimid

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

rexulti

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of schizophrenia the patient must have documented trial and failure or intolerance to one formulary generic antipsychotic (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone) AND Saphris. For major depressive disorder, the patient must have documented trial and failure or intolerance to two of the following: escitalopram, sertraline, fluoxetine, paroxetine, venlafaxine, venlafaxine ER, citalopram, mirtazapine, desvenlafaxine or duloxetine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

risperdal consta

Products Affected

- RISPERDAL CONSTA
  INTRAMUSCULAR SUSPENSION
  RECONSTITUTED ER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ROZLYTREK

Products Affected

- ROZLYTREK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

rubraca

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC will be monitored for the duration of therapy as indicated in compendia. For appropriate indications, documentation of FDA approved test confirming mutation. Documentation of patient's treatment history for related conditions.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

rydapt

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that Complete Blood Count (CBC with differential) will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

secuado

Products Affected

- *secuado*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient must have documented trial and failure or intolerance to one formulary generic antipsychotics (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone) AND Saphris
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

seizures, benzodiazepines and barbiturates

Products Affected

- *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*
- DIAZEPAM INTENSOL
- *diazepam oral concentrate*
- *diazepam oral solution 5 mg/5ml*
- *diazepam oral tablet*
- *phenobarbital oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For use in patients with panic disorders or anxiety disorders, the patient must have a documented trial and failure or intolerance to one formulary antidepressant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

seizures, other

Products Affected

- BANZEL ORAL SUSPENSION
- BANZEL ORAL TABLET
- *clobazam oral suspension*
- *clobazam oral tablet*
- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For treatment of Lennox Gastaut Syndrome, patient must have documented trial and failure or intolerance to one formulary anticonvulsant agent that is indicated for Lennox-Gastaut Syndrome. For use in patients with anxiety disorders, the patient must have documented trial and failure or intolerance to one formulary antidepressant (eg SNRI or SSRI).
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

serostim

Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 12 weeks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

signifor

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sildenafil oral

Products Affected

- *sildenafil citrate oral suspension reconstituted*

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For sildenafil suspension: Documentation was submitted documenting trial with sildenafil tablet OR the patient has another documented medical reason for not taking sildenafil tablet to manage their medical condition.
Indications	All Medically-accepted Indications.
Off Label Uses	

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

sirturo

Products Affected

- SIRTURO ORAL TABLET 100 MG
- *sirturo oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior trial and failure of first-line TB regimen containing isoniazid and rifampin. Provider attests that baseline LFT and EKG will be obtained prior to initiation of therapy and throughout the duration of treatment with Sirturo
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 24 weeks.
Other Criteria	Documentation was submitted (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) that the member is currently taking three additional antimycobacterial drugs in combination to treat MDR-TB.
Indications	All Medically-accepted Indications.
Off Label Uses	

sodium phenylbutyrate

Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*
- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sofosbuvir/velpatasvir

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Labs within 3 months of request: ALT/AST, and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 12-24 weeks based on AASLD-IDSA guidelines
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

somavert

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

SPRAVATO

Products Affected

- SPRAVATO (56 MG DOSE)
- SPRAVATO (84 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sprycel

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential and electrolyte levels will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

stelara

Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function test and blood pressure will be monitored for the duration of therapy as indicated in compendia. Documentation of patient's treatment history for related conditions.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sucraid

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sutent

Products Affected

- SUTENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential, liver function, blood glucose levels and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

sylatron

Products Affected

- SYLATRON SUBCUTANEOUS KIT
  200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Exclusion Criteria	A history of autoimmune hepatitis or hepatic decompensation (Child-Pugh greater than 6[class B and C]).
Required Medical Information	For appropriate indication, documentation of definitive surgical resection including complete lymphadenectomy within 84 days of initiating treatment.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

symdeko

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that AST, ALT and bilirubin will be monitored prior to treatment initiation and throughout the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in treatment of cystic fibrosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

symlin

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For new starts HbA1C values within 90 days of request should be provided showing the following: 1) for patients with type 2 diabetes HbA1C is greater than or equal to 8% despite receiving insulin therapy or 2) for pateints with type 1 diabetes, HbA1C is greater than or equal to 7% despite receiving insulin therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial or intolerance to two formulary anti-diabetic agents.
Indications	All Medically-accepted Indications.
Off Label Uses	

synarel

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

syndros

Products Affected

- SYNDROS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation of either trial/failure or a medical reason (e.g. intolerance or hypersensitivity) for not being able to use dronabinol capsules
Indications	All Medically-accepted Indications.
Off Label Uses	

synribo

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tabloid

Products Affected

- TABLOID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential and liver function test will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tabrecta

Products Affected

- *tabrecta*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tafinlar

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For appropriate indications, confirmation of mutation as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tagrisso

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior treatment history for related condition. For appropriate indications, confirmation of mutation as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

talzenna

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood counts including platelets and blood chemistries will be completed for the duration of therapy as indicated in compendia. For appropriate indications, confirmation of mutation as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tasigna

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential, liver function, electrolytes, lipid profile and glucose will be monitored for the duration of therapy as indicated in compendia. Documentation of prior treatment history for related condition.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tazverik

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

teflaro

Products Affected

- TEFLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

thiola

Products Affected

- THIOLA
- THIOLA EC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tibsovo

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that complete blood counts and blood chemistries will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

topical antineoplastic retinoids

Products Affected

- PANRETIN
- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

topical testosterone

Products Affected

- *testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient initiating topical testosterone therapy for hypogonadism must have both of the following characteristics of hypogonadism: 1) symptoms associated with hypogonadism (e.g. unexplained mild anemia, low libido, decreased energy, etc.) 2) Two instances of low serum total or free testosterone, as defined by the reference range by the lab. For all patients, provider attests that PSA levels, hemoglobin, hematocrit and testosterone levels will be monitored periodically throughout the treatment as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

toremifene

Products Affected

- *toremifene citrate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that electrolytes levels (including magnesium, potassium and calcium) will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial and failure or intolerance to tamoxifen.
Indications	All Medically-accepted Indications.
Off Label Uses	

transdermal lidocaine

Products Affected

- *lidocaine external patch 5 %*
- ZTLIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tremfya

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

trientine

Products Affected

- *trientine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented penicillamine intolerance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Request will be authorized until the end of the contract year.
Indications	All Medically-accepted Indications.
Off Label Uses	

trikafta

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis mutation
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in treatment of cystic fibrosis
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tukysa

Products Affected

- TUKYSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TURALIO

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tykerb

Products Affected

- *lapatinib ditosylate*
- TYKERB

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For patients with advanced or metastatic breast cancer who are HER2 positive and has had a trial at therapeutic doses with an anthracycline (i.e. Doxorubicin or Epirubicin) a taxane (i.e. Docetaxel or Paclitaxel) and Herceptin (trastuzumab) then documentation of concurrent use of Xeloda (capecitabine). For patients who are postmemopausal with hormone receptor positive and HER2 positive then documentation of concurrent use of Femara (letrozole).
Indications	All Medically-accepted Indications.
Off Label Uses	

tymlos

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable: The patient has a documented treatment failure or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not utilizing an oral bisphosphonate to manage their medical condition AND The therapy does not exceed the therapy maximum of 2 years.
Indications	All Medically-accepted Indications.
Off Label Uses	

vabomere

Products Affected

- VABOMERE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of a consultation with an infectious disease specialist.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized for 14 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

valtoco

Products Affected

- *valtoco 10 mg dose*
- *valtoco 15 mg dose*
- *valtoco 20 mg dose*
- *valtoco 5 mg dose*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that diazepam rectal gel cannot be used.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vandetanib

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that serum electrolytes, TSH, ECG and blood pressure will be monitored prior to initiation and throughout the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or endocrinologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

venclexta

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ventavis

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification and PAH Functional Class.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

verzenio

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function tests and complete blood cell count will be assessed prior to initiation and throughout the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hematologist or an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vigabatrin

Products Affected

- *vigabatrin*
- VIGADRONE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If the patient has a diagnosis of infantile spasms or West syndrome, the request will be approved. Patient must have a diagnosis of refractory complex partial seizures who is currently receiving another antiepileptic drug and the patient has experienced treatment failure from two previous formulary antiepileptic agents (lamotrigine, gabapentin, carbamazepine, topiramate, tiagabine, oxcarbazepine, levetiracetam, phenytoin, zonisamide, divalproex).
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vitrakvi

Products Affected

- VITRAKVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmation of the presence of a NTRK gene fusion. Provider attests that liver tests will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vizimpro

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For appropriate indications, confirmation of mutation as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

vmat-2 inhibitors

Products Affected

- AUSTEDO
- INGREZZA
- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist, clinical geneticist, or psychiatrist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	If the request is for tetrabenazine, request will be approved. For Ingrezza, trial and failure or medical reason for not using the tetrabenazine for tardive dyskinesia. For Austedo, trial and failure or medical reason for not using the following if applicable for submitted diagnosis 1) Chorea associated with Huntington disease- trial of tetrabenazine. 2) Tardive dyskinesia -trial of tetrabenazine and Ingrezza. Reauthorization: Confirmation of improvement in tardive dyskinesia symptoms or chorea associated with Huntington disease symptoms.
Indications	All Medically-accepted Indications.
Off Label Uses	

vosevi

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Labs within 3 months of request: ALT or AST, detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	Request will be authorized for 12 weeks as per AASLD-IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD-IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

votrient

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

white blood cell stimulators

Products Affected

- GRANIX
- LEUKINE INJECTION SOLUTION RECONSTITUTED
- NEULASTA ONPRO
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE
- NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE
- ZARXIO
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For treatment or prophylaxis of febrile neutropenia, provider attests that ANC and temperature will be regularly monitored throughout the duration of therapy
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or an infectious disease specialist.
Coverage Duration	For new starts only: 4 months. All others: until end of the year.
Other Criteria	For Neupogen, Granix and Neulasta requests, documentation of trial of, or a medical reason for not being able to use Zarxio (including inability to administer or comply with Zarxio, or known intolerance to filgrastim products). Re-authorization criteria: diagnosis of chronic neutropenia or a medical reason for continued need for GCSF. Reauthorization will be approved until end of the year
Indications	All Medically-accepted Indications.
Off Label Uses	

xalkori

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential and liver function tests will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xatmep

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or rheumatologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Specialist for submitted diagnosis
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Indications	All Medically-accepted Indications.
Off Label Uses	

xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	Patients with baseline hypocalcemia
Required Medical Information	Criteria for new starts: Serum calcium levels for all indications
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Skeletal related events and giant cell bone tumor:contract year. Malignant hypercalcemia: 4months
Other Criteria	Reauthorization criterion for skeletal related events or giant cell bone tumor:statement of continued need for use of Xgeva. Reauthorization criteria for malignant hypercalcemia: albumin-adjusted serum calcium level below 12.5mg/dl within 30 days of request and statement of continued need for Xgeva.
Indications	All Medically-accepted Indications.
Off Label Uses	

xifaxan

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of hepatic encephalopathy: patient must have documentation of trial and failure, intolerance, or contraindication to lactulose. For diagnosis of irritable bowel syndrome with diarrhea (IBS D), the patient has a documentation of trial, intolerance, or contraindication to loperamide and dicyclomine. For diagnosis of travelers diarrhea caused by noninvasive strains of E. Coli (with no bloody stools or fever), patient must be intolerant to or must have had trial of at least 3 days of one of the following agents: ciprofloxacin, ofloxacin, levofloxacin or azithromycin.
Age Restrictions	
Prescriber Restrictions	For hepatic encephalopathy, gastroenterologist, hepatologist. For IBS-D, gastroenterologist
Coverage Duration	For hepatic encephalopathy:end of contract year. For IBS D: 8 weeks. For travelers diarrhea: 3 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xolair

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria for new starts for the diagnosis of moderate to severe persistent allergic asthma: 1) evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen, AND 2) pretreatment serum IgE levels greater than 30 and less than 1300 IU/mL, AND 3) symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months, or medical justification has been provided indicating why a patient is not able to utilize a high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) to treat their medical condition. Criteria for new starts for the diagnosis of chronic idiopathic urticaria include: 1) Patient must have inadequate symptomatic relief despite trial of two weeks of two different oral antihistamine therapies (unless contraindicated) and 2) Patient's disease must be severe enough to warrant short term systemic corticosteroid therapy for management of urticaria.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a pulmonologist or an allergist.
Coverage Duration	Initial authorization: 6 months. Reauthorization until end of contract year.
Other Criteria	For asthma patients, one of the following must be met during Xolair use for continuation of therapy: 1) reduction in asthma exacerbation resulting in systemic steroid use and/or hospitalization, 2) reduction of rescue inhaler use, or 3) documentation of improvement in pulmonary function tests since baseline (prior to initiation of Xolair). Criteria for continuation of therapy for chronic idiopathic urticaria: continued improvement of symptoms associated with urticaria within 6 months of Xolair use.

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	

xospata

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmation of the FMS-like tyrosine kinase 3 (FLT3) mutations in the blood or bone marrow with a FDA approved test. Provider attests that ECG and blood chemistries will be completed prior to initiation of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

XPOVIO

Products Affected

- XPOVIO (100 MG ONCE WEEKLY)
- *xpovio (40 mg once weekly)*
- *xpovio (40 mg twice weekly)*
- XPOVIO (60 MG ONCE WEEKLY)
- *xpovio (60 mg twice weekly)*
- XPOVIO (80 MG ONCE WEEKLY)
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	The request will be authorized until the end of the contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xtandi

Products Affected

- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or an urologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xuriden

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be an endocrinologist, metabolic specialist, clinical geneticist or hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a sleep specialist or a neurologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	For treatment of somnolence associated with narcolepsy, patient must have documentation of either trial of or a medical reason for being unable to use an approved formulary CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.)
Indications	All Medically-accepted Indications.
Off Label Uses	

yonsa

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function test will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

zejula

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that that Complete Blood Count (CBC with differential), blood pressure, and heart rate will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

zelboraf

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function, ECG and electrolyte will be monitored for the duration of therapy as indicated in compendia. For appropriate indication, documentation that patient has a BRAF V600E or V600K mutation as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

zeposia

Products Affected

- ZEPOSIA
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	Documentation showing trial of two of the following agents: Aubagio, glatiramer, or glatopa OR the patient has another documented medical reason (intolerance, hypersensitivity, etc) for not taking any of these therapies to manage their medical condition.
Indications	All Medically-accepted Indications.
Off Label Uses	

zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC, electrolytes, serum glucose, and serum creatinine will be monitored for the duration of therapy as indicated in compendia
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

zydelig

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that CBC with differential and liver function test will be completed for the duration of therapy as indicated in compendia. Documentation of prior treatment history for related conditions.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

zykadia

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function, heart rate and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

zyprexa relprevv

Products Affected

- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG, 405 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The member has a documented history of receiving oral olanzapine without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing one of these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

zytiga

Products Affected

- *abiraterone acetate*
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Provider attests that liver function tests, blood pressure and electrolytes will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an oncologist or an urologist.
Coverage Duration	Request will be authorized until the end of the contract year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

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