# CRITERIOS DE AUTORIZACIÓN PREVIA

**1° de enero - 31 de diciembre**

# 2025

LEON HEALTH

H4286_2025PRIORAUTHCRIT_S_C

# ABATACEPT SQ

## Products Affected

- ORENCIA
- ORENCIA CLICKJECT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ, RINVOQ, SKYRIZI. RENEWAL: RA, PJIA, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ABEMACICLIB

## Products Affected

- VERZENIO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ABIRATERONE

## Products Affected

- *abiraterone*
- *abirtega*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | METASTATIC HIGH-RISK CASTRATION-SENSITIVE PROSTATE CANCER, METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ABIRATERONE SUBMICRONIZED

## Products Affected

- YONSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ACALABRUTINIB

## Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ADAGRASIB

## Products Affected

- KRAZATI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ADALIMUMAB

**Products Affected**

- HADLIMA
- HADLIMA PUSHTOUCH
- HADLIMA(CF)
- HADLIMA(CF) PUSHTOUCH
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- SIMLANDI(CF)
- SIMLANDI(CF) AUTOINJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPTHALMOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# AFATINIB

## Products Affected

- GILOTRIF

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS. |
| **Other Criteria** | METASTATIC NSCLC WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AKEEGA

## Products Affected

- AKEEGA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) AND used in combination with prednisone |
| **Age Restrictions** | 18 years or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ALECTINIB

## Products Affected

- ALECENSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ALPELISIB

## Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AMBRISENTAN

## Products Affected

- *ambrisentan*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: 1) DOCUMENTED CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) OF 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | PAH: INITIAL: PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS. RENEWAL: 1) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE, OR 2) A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AMIFAMPRIDINE

## Products Affected

- FIRDAPSE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# APALUTAMIDE

## Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): (1) HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC, METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): (1) RECEIVED A BILATERAL ORCHIECTOMY, (2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR (3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE ANALOG. RENEWAL: DIAGNOSIS OF NMCRPC OR MCSPC. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# APOMORPHINE

## Products Affected

- *apomorphine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# APREMILAST

## Products Affected

- OTEZLA ORAL TABLET 20 MG, 30 MG
- OTEZLA STARTER

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: MILD PLAQUE PSORIASIS (PSO): ONE OF THE FOLLOWING: 1) PSORIASIS COVERING 2 PERCENT OF BODY SURFACE AREA (BSA), 2) STATIC PHYSICIAN GLOBAL ASSESSMENT (SPGA) SCORE OF 2, OR 3) PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 2 TO 9. MODERATE TO SEVERE PSO: 1) PSORIASIS COVERING 3 PERCENT OR MORE OF BSA, OR 2) PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ, RINVOQ, SKYRIZI. MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC AGENT (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) AND ONE CONVENTIONAL TOPICAL AGENT (E.G., PUVA, UVB, TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI, TREMFYA. BEHCETS DISEASE: 1) PATIENT HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID, ORAL CORTICOSTEROID). RENEWAL: PSA, PSO, BEHCETS DISEASE: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ASCIMINIB

## Products Affected

- SCEMBLIX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOID LEUKEMIA (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND SCEMBLIX IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ATOGEPANT

## Products Affected

- QULIPTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | EPISODIC MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AUGTYRO

## Products Affected

- AUGTYRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | |
| **Age Restrictions** | 12 years or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AVACOPAN

## Products Affected

- TAVNEOS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | ANTI-NEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS: INITIAL: ANCA SEROPOSITIVE (ANTI-PR3 OR ANTI-MPO). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ANCA-ASSOCIATED VASCULITIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 6 MONTHS. |
| **Other Criteria** | ANCA-ASSOCIATED VASCULITIS: RENEWAL: CONTINUES TO BENEFIT FROM THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AVAPRITINIB

## Products Affected

- AYVAKIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AVATROMBOPAG

### Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: CHRONIC LIVER DISEASE (CLD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, ENDOCRINOLOGIST, OR A SURGEON. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST. |
| **Coverage Duration** | CLD: 1 MONTH. CHRONIC ITP: INITIAL: 2 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: CLD: 1) PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET, AND 2) NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G., ROMIPLOSTIM, ELTROMBOPAG, ETC.). CHRONIC ITP: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS OR INSUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: CHRONIC ITP: PATIENT HAD A CLINICAL RESPONSE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AXITINIB

## Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AZACITIDINE

## Products Affected

- ONUREG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# AZTREONAM

## Products Affected

- CAYSTON

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | 7 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BECAPLERMIN

## Products Affected

- REGRANEX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | DIABETIC NEUROPATHIC ULCERS: PRESCRIBED BY OR IN CONSULTATION WITH A VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST, PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC OR INFECTIOUS DISEASE SPECIALIST. |
| **Coverage Duration** | 3 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BEDAQUILINE

## Products Affected

- SIRTURO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 24 WEEKS |
| **Other Criteria** | PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS (MDR-TB): SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MDR-TB. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BELIMUMAB

## Products Affected

- BENLYSTA SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. LUPUS NEPHRITIS (LN): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | INITIAL: SLE: CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PATIENT HAD CLINICAL IMPROVEMENT. LN: IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BELUMOSUDIL

## Products Affected

- REZUROCK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BELZUTIFAN

## Products Affected

- WELIREG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BENRALIZUMAB

## Products Affected

- FASENRA
- FASENRA PEN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. |
| **Coverage Duration** | INITIAL: 4 MONTHS, RENEWAL: 12 MONTHS. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. RENEWAL: 1) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BETAINE

## Products Affected

- *betaine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BEXAROTENE

## Products Affected

- *bexarotene oral*
- *bexarotene topical*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BINIMETINIB

## Products Affected

- MEKTOVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BOSENTAN

## Products Affected

- *bosentan*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: 1) DOCUMENTED CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) OF 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | PAH: INITIAL: 1) DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASE IN BILIRUBIN BY 2 OR MORE TIMES ULN, AND 2) NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: 1) NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE, 2) AGES 3 TO 17 YEARS OF AGE: A) DEMONSTRATED IMPROVEMENT IN PVR, OR B) REMAINED STABLE OR SHOWN IMPROVEMENT IN EXERCISE ABILITY, 3) AGES 18 YEARS OR OLDER: A) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE, OR B) A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. |
| **Indications** | All FDA-approved Indications. |

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BOSUTINIB

## Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | PREVIOUSLY TREATED (Ph+ CML): MUTATIONAL ANALYSIS PRIOR TO INITIATION AND BOSULIF IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE. |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BRIGATINIB

## Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# BRONCHITOL

## Products Affected

- BRONCHITOL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of Cystic fibrosis of the lung |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# C1 ESTERASE INHIBITOR-HAEGARDA

### Products Affected

- HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST. |
| **Coverage Duration** | INITIAL AND RENEWAL: 12 MONTHS. |
| **Other Criteria** | HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CABOZANTINIB

## Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CABOZANTINIB S-MALATE - CABOMETYX

## Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CANNABIDIOL

## Products Affected

- EPIDIOLEX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | DRAVET SYNDROME (DS), LENNOX-GASTAUT SYNDROME (LGS), TUBEROUS SCLEROSIS COMPLEX (TSC): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: LENNOX-GASTAUT SYNDROME (LGS): TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING ANTIEPILEPTIC MEDICATIONS: RUFINAMIDE, FELBAMATE, CLOBAZAM, TOPIRAMATE, LAMOTRIGINE, CLONAZEPAM. RENEWAL: DS, LGS, TSC: CONFIRMATION OF DIAGNOSIS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CAPLACIZUMAB YHDP

### Products Affected

- CABLIVI INJECTION KIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ACQUIRED THROMBOTIC THROMBOCYTOPENIA PURPURA (ATTP): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | ATTP: CABLIVI WAS PREVIOUSLY INITIATED AS PART OF THE FDA APPROVED TREATMENT REGIMEN IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY WITHIN AN INPATIENT SETTING. THE PATIENT HAS NOT EXPERIENCED MORE THAN TWO RECURRENCES OF ATTP WHILE ON CABLIVI THERAPY (I.E., NEW DROP IN PLATELET COUNT REQUIRING REPEAT PLASMA EXCHANGE DURING 30 DAYS POST-PLASMA EXCHANGE THERAPY [PEX] AND UP TO 28 DAYS OF EXTENDED THERAPY). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CAPMATINIB

## Products Affected

- TABRECTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CARGLUMIC ACID

## Products Affected

- *carglumic acid*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: ACUTE, CHRONIC HYPERAMMONEMIA (HA) DUE TO N ACETYLGLUTAMATE SYNTHASE (NAGS) DEFICIENCY: NAGS GENE MUTATION IS CONFIRMED BY BIOCHEMICAL OR GENETIC TESTING. ACUTE HA DUE TO PROPIONIC ACIDEMIA (PA): 1) CONFIRMED BY THE PRESENCE OF ELEVATED METHYLCITRIC ACID AND NORMAL METHYLMALONIC ACID, OR 2) GENETIC TESTING CONFIRMING MUTATION IN THE PCCA OR PCCB GENE. ACUTE HA DUE TO METHYLMALONIC ACIDEMIA (MMA): 1) CONFIRMED BY THE PRESENCE OF ELEVATED METHYLMALONIC ACID, METHYLCITRIC ACID, OR 2) GENETIC TESTING CONFIRMING MUTATION IN THE MMUT, MMA, MMAB OR MMADHC GENES. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | ACUTE HA DUE TO NAGS/PA/MMA: 7 DAYS. CHRONIC HA DUE TO NAGS: INITIAL: 6 MOS, RENEWAL: 12 MOS. |
| **Other Criteria** | RENEWAL: CHRONIC HA DUE TO NAGS: PATIENT HAS SHOWN CLINICAL IMPROVEMENT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CERITINIB

## Products Affected

- ZYKADIA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CERTOLIZUMAB PEGOL

### Products Affected

- CIMZIA POWDER FOR RECONST
- CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, TREMFYA, XELJANZ, RINVOQ, SKYRIZI. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI, TREMFYA. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, SKYRIZI. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX, RINVOQ. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS. RENEWAL: RA, PSA, AS, PSO, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CLADRIBINE

### Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL/RENEWAL: 48 WEEKS. |
| **Other Criteria** | MS: INITIAL: HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF 2 CYCLES IN EACH). RENEWAL: 1) HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE, 2) DOES NOT HAVE LYMPHOPENIA, AND 3) HAS NOT RECEIVED A TOTAL OF TWO YEARS OF MAVENCLAD TREATMENT (I.E., TWO YEARLY TREATMENT COURSES OF 2 CYCLES IN EACH). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CLOBAZAM-SYMPAZAN

## Products Affected

- SYMPAZAN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | LENNOX-GASTAUT SYNDROME (LGS): THERAPY IS PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | LGS: 1) PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION, AND 2) TRIAL OF OR CONTRAINDICATION TO A FORMULARY CLOBAZAM AGENT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# COBIMETINIB

## Products Affected

- COTELLIC

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CORTICOTROPIN

## Products Affected

- ACTHAR
- ACTHAR SELFJECT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | INITIAL: NOT APPROVED FOR DIAGNOSTIC PURPOSES. |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST. |
| **Coverage Duration** | INFANTILE SPASMS AND MS: 28 DAYS. ALL OTHER FDA APPROVED INDICATIONS: INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS: TRIAL OF OR CONTRAINDICATION TO INTRAVENOUS (IV) CORTICOSTEROIDS. RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MS: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS. PART B BEFORE PART D STEP THERAPY, APPLIES ONLY TO BENEFICIARIES IN AN MA-PD PLAN. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | Yes |

# CRIZOTINIB

## Products Affected

- XALKORI ORAL CAPSULE
- XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# CYSTEAMINE HYDROCHLORIDE

## Products Affected

- CYSTARAN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DABRAFENIB

## Products Affected

- TAFINLAR ORAL CAPSULE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DACOMITINIB

## Products Affected

- VIZIMPRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | METASTATIC NSCLC: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DALFAMPRIDINE

## Products Affected

- *dalfampridine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | MULTIPLE SCLEROSIS (MS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | MS: INITIAL: HAS SYMPTOMS OF A WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA. RENEWAL: IMPROVEMENT IN WALKING ABILITY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DAROLUTAMIDE

## Products Affected

- NUBEQA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL AND RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): PATIENT HAS HIGH RISK PROSTATE CANCER (I.E., RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND ONE OF THE FOLLOWING: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. METASTATIC HORMONE-SENSITIVE PROSTATE CANCER (MHSPC): 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. RENEWAL: NMCRPC: NO ADDITONAL CRITERIA REQUIRED. MHSPC: 1) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. |
| **Indications** | All FDA-approved Indications. |

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DASATINIB

## Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*
- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DECITABINE/CEDAZURIDINE

## Products Affected

- INQOVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DEFERASIROX

## Products Affected

- *deferasirox*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT): 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) AND 2) LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NTDT: 1) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR 2) LIC OF 3 MG FE/G DRY WEIGHT OR GREATER. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: CHRONIC IRON OVERLOAD: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | INITIAL FOR ALL INDICATIONS: FORMULARY VERSION OF DEFERASIROX SPRINKLE: TRIAL OF OR CONTRAINDICATION TO GENERIC DEFERASIROX TABLET OR TABLET FOR ORAL SUSPENSION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# DEFERIPRONE

## Products Affected

- *deferiprone*
- FERRIPROX (2 TIMES A DAY)
- FERRIPROX ORAL SOLUTION

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | TRANSFUSIONAL IRON OVERLOAD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | INITIAL: TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROMES: 1) TRIAL OF, CONTRAINDICATION, INTOLERABLE TOXICITIES, OR CLINICALLY SIGNIFICANT ADVERSE EFFECTS TO ONE OF THE FOLLOWING: FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE, OR 2) CURRENT CHELATION THERAPY (I.E., FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE) IS INADEQUATE. TRANSFUSIONAL IRON OVERLOAD DUE TO SICKLE CELL DISEASE OR OTHER ANEMIAS: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DEFERASIROX OR DEFEROXAMINE. RENEWAL (ALL INDICATIONS): SERUM FERRITIN LEVELS CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DENOSUMAB-XGEVA

## Products Affected

- XGEVA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DEUTETRABENAZINE

### Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR TITRATION KT(WK1-4)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HUNTINGTON DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | TARDIVE DYSKINESIA: PATIENT HAS A HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DICLOFENAC GEL

## Products Affected

- *diclofenac sodium topical gel 3 %*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DICLOFENAC TOPICAL SOLUTION

## Products Affected

- *diclofenac sodium topical solution in metered-dose pump*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 MONTHS |
| **Other Criteria** | OSTEOARTHRITIS OF THE KNEE: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF DICLOFENAC SODIUM 1% TOPICAL GEL AND A FORMULARY VERSION OF DICLOFENAC SODIUM 1.5% TOPICAL DROPS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DIMETHYL FUMARATE

## Products Affected

- *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DIROXIMEL FUMARATE

## Products Affected

- VUMERITY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DRONABINOL

## Products Affected

- *dronabinol*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 MONTHS |
| **Other Criteria** | NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY: TRIAL OF OR CONTRAINDICATION TO ONE ANTIEMETIC THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D FOR THE INDICATION OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DROXIDOPA

## Products Affected

- *droxidopa*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH): INITIAL: 1) BASELINE BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE POSITION. 2) A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | NOH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST. |
| **Coverage Duration** | INITIAL: 3 MONTHS RENEWAL: 12 MONTHS |
| **Other Criteria** | NOH: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DUPILUMAB

### Products Affected

- DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML
- DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML, 200 MG/1.14 ML, 300 MG/2 ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS. EOSINOPHILIC ESOPHAGITIS (EOE): DIAGNOSIS CONFIRMED BY ESOPHAGOGASTRODUODENOSCOPY (EGD) WITH BIOPSY. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: AD, PN: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CRSWNP: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. EOE: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, ALLERGIST, OR IMMUNOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# DUVELISIB

## Products Affected

- COPIKTRA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# EDARAVONE

## Products Affected

- RADICAVA ORS STARTER KIT SUSP

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | AMYOTROPHIC LATERAL SCLEROSIS (ALS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR ALS SPECIALIST AT AN ALS SPECIALTY CENTER OR CARE CLINIC. |
| **Coverage Duration** | ALS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | ALS: INITIAL: 1) DURATION OF DISEASE (FROM ONSET OF SYMPTOMS) IS LESS THAN OR EQUAL TO 2 YEARS, 2) NORMAL RESPIRATORY FUNCTION, 3) HAS MILD TO MODERATE ALS WITH A SCORE OF 2 OR HIGHER IN ALL OF THE FOLLOWING 12 ITEMS OF THE AMYOTROPHIC LATERAL SCLEROSIS FUNCTIONAL RATING SCALE REVISED (ALSFRS-R): SPEECH, SALIVATION, SWALLOWING, HANDWRITING, CUTTING FOOD, DRESSING AND HYGIENE, TURNING IN BED, WALKING, CLIMBING STAIRS, DYSPNEA, ORTHOPNEA, RESPIRATORY INSUFFICIENCY, AND 4) TRIAL OF RILUZOLE TABLET OR CURRENTLY TAKING RILUZOLE TABLET. RENEWAL: 1) DOES NOT REQUIRE INVASIVE VENTILATION, AND 2) HAS IMPROVED BASELINE FUNCTIONAL ABILITY OR HAS MAINTAINED A SCORE OF 2 OR HIGHER IN ALL 12 ITEMS OF THE ALSFRS-R. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# ELACESTRANT

## Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ELAGOLIX SODIUM

## Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS. |
| **Age Restrictions** | MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 18 YEARS OF AGE OR OLDER. |
| **Prescriber Restrictions** | MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST. |
| **Coverage Duration** | MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: INITIAL: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 2) TRIAL OF OR CONTRAINDICATION TO A NSAID AND PROGESTIN-CONTAINING PREPARATION. RENEWAL: 1) IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ELAPEGADEMASE-LVLR

### Products Affected

- REVCOVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | ADENOSINE DEAMINASE SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | ADA-SCID: INITIAL: ADA-SCID AS MANIFESTED BY ONE OF THE FOLLOWING: (1) CONFIRMATORY GENETIC TEST OR (2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPTOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA). RENEWAL: 1) IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE, AND 2) HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ELEXACAFTOR-TEZACAFTOR-IVACAFTOR

### Products Affected

- TRIKAFTA ORAL TABLETS, SEQUENTIAL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: LIFETIME. |
| **Other Criteria** | CF: RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ELIGLUSTAT

## Products Affected

- CERDELGA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ELTROMBOPAG

## Products Affected

- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST. |
| **Coverage Duration** | ITP: INITIAL: 2 MO, RENEWAL: 12 MO. HEPATITIS C, SEVERE APLASTIC ANEMIA: 12 MO. |
| **Other Criteria** | INITIAL: PERSISTENT OR CHRONIC IMMUNE THROMBOCYTOPENIA PURPURA (ITP): TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ALL INDICATIONS: APPROVAL FOR PROMACTA ORAL SUSPENSION PACKETS REQUIRES A TRIAL OF PROMACTA TABLETS OR PATIENT IS UNABLE TO TAKE TABLET FORMULATION. RENEWAL: ITP: PATIENT HAS SHOWN A CLINICAL RESPONSE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ENASIDENIB

## Products Affected

- IDHIFA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ENCORAFENIB

## Products Affected

- BRAFTOVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ENTRECTINIB

## Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- ROZLYTREK ORAL PELLETS IN PACKET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ENZALUTAMIDE

## Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# EPOETIN ALFA-EPBX

### Products Affected

- RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE, OR CANCER CHEMOTHERAPY: HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE, NON-CARDIAC, NON-VASCULAR SURGERY: HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CKD: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL, OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA RELATED TO ZIDOVUDINE: HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. CANCER CHEMOTHERAPY: 1) HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL, OR 2) THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | ANEMIA FROM CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE: INITIAL/RENEWAL: 12 MONTHS. SURGERY: 1 MONTH. |
| **Other Criteria** | RENEWAL: CKD: NOT RECEIVING DIALYSIS TREATMENT. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# ERDAFITINIB

## Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ERLOTINIB

## Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | METASTATIC NSCLC WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ETANERCEPT

## Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. |
| **Age Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), PSORIATIC ARTHRITIS (PSA): 18 YEARS OR OLDER. |
| **Prescriber Restrictions** | INITIAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE: IS REQUIRED. PJIA, PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. RENEWAL: RA, PJIA, PSA, AS, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION. |

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# EVEROLIMUS

## Products Affected

- *everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus (antineoplastic) oral tablet for suspension*
- *torpenz oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FEDRATINIB

## Products Affected

- INREBIC

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | MYELOFIBROSIS: INITIAL: TRIAL OF OR CONTRAINDICATION TO JAKAFI (RUXOLITINIB). RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FENTANYL CITRATE

## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | CANCER RELATED PAIN: 1) CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION, AND 2) TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR PATIENT HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FEZOLINETANT

## Products Affected

- VEOZAH

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | MENOPAUSAL VASOMOTOR SYMPTOMS (VMS): INITIAL: 1) EXPERIENCES 7 OR MORE HOT FLASHES PER DAY, AND 2) TRIAL OF OR CONTRAINDICATION TO HORMONAL THERAPY (E.G., ESTRADIOL TRANSDERMAL PATCH, ORAL CONJUGATED ESTROGENS). RENEWAL: 1) CONTINUED NEED FOR VMS TREATMENT (I.E., PERSISTENT HOT FLASHES), AND 2) REDUCTION IN VMS FREQUENCY OR SEVERITY DUE TO VEOZAH TREATMENT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FILGRASTIM-AAFI

## Products Affected

- NIVESTYM

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FILGRASTIM-SNDZ

## Products Affected

- ZARXIO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: NIVESTYM. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FINERENONE

## Products Affected

- KERENDIA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FINGOLIMOD

## Products Affected

- *fingolimod*
- GILENYA ORAL CAPSULE 0.25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FIRMAGON

## Products Affected

- FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG, 80 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of advanced prostate cancer |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FREMANEZUMAB-VFRM

### Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FRUZAQLA

## Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic colorectal cancer (mCRC) and all of the following: A.) patient has been previously treated with fluoropyrimidine, oxaliplatin, irinotecan-based chemotherapy, B.) an anti-VEGF therapy, and C.) if RAS wild-type and medically appropriate, patient has also been previously treated with anti-EGFR therapy |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or hematologist |
| **Coverage Duration** | 3 months |
| **Other Criteria** | None |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# FUTIBATINIB

## Products Affected

- LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INTRAHEPATIC CHOLANGIOCARCINOMA (ICCA): COMPLETE A COMPREHENSIVE OPHTHALMOLOGICAL EXAMINATION, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT), PRIOR TO THE INITIATION OF THERAPY AND AT THE RECOMMENDED SCHEDULED INTERVALS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# GALCANEZUMAB-GNLM

### Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X 3)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: MIGRAINE PREVENTION: 6 MOS. EPISODIC CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL): 12 MOS. |
| **Other Criteria** | INITIAL: MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: MIGRAINE PREVENTION: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY, AND 2) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION. EPISODIC CLUSTER HEADACHE: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# GANAXOLONE

## Products Affected

- ZTALMY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# GEFITINIB

## Products Affected

- *gefitinib*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | METASTATIC NSCLC WITH EGFR MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# GILTERITINIB

## Products Affected

- XOSPATA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# GLASDEGIB

## Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# GLATIRAMER

## Products Affected

- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# GLECAPREVIR/PIBRENTASVIR

### Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | HCV RNA LEVEL WITHIN PAST 6 MONTHS |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. |
| **Other Criteria** | 1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE, 3) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR, DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY, EPCLUSA, HARVONI, VOSEVI, OR ZEPATIER, 4) PATIENT MUST NOT HAVE PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR, AND 5) DOES NOT HAVE MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# GLP1 AGONISTS

## Products Affected

- MOUNJARO
- OZEMPIC
- RYBELSUS
- TRULICITY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Must meet all of the following 1.) The drug is prescribed for an FDA-approved indication, 2.) For a diagnosis of Type 2 Diabetes Mellitus the patient has a trial and failure, contraindication or intolerance to metfomin |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# GUSELKUMAB

## Products Affected

- TREMFYA
- TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, SCALP, OR GENITAL AREA. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# HIGH CONCENTRATION ORAL OPIOID SOLUTIONS

## Products Affected

- *morphine concentrate oral solution*
- *oxycodone oral concentrate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | OPIOID TOLERANT: 12 MONTHS. HOSPICE, PALLIATIVE CARE OR END OF LIFE CARE: LIFETIME. |
| **Other Criteria** | 1) OPIOID TOLERANT (I.E. PREVIOUS USE OF 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, 60 MG ORAL HYDROCODONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID) AND HAS TROUBLE SWALLOWING OPIOID TABLETS, CAPSULES, OR LARGE VOLUMES OF LIQUID, OR 2) ENROLLED IN HOSPICE OR PALLIATIVE CARE OR END OF LIFE CARE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IBRUTINIB

## Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 280 MG, 420 MG 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG,

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ICATIBANT

## Products Affected

- *icatibant*
- *sajazir*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | HEREDITARY ANGIOEDEMA (HAE): DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HAE: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | HAE: NO CONCURRENT USE WITH OTHER MEDICATIONS FOR TREATMENT OF ACUTE HAE ATTACKS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IDELALISIB

## Products Affected

- ZYDELIG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IMATINIB

## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*
- IMKELDI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | ADJUVANT GASTROINTESTINAL STROMAL TUMOR TREATMENT: 36 MONTHS. ALL OTHER DIAGNOSES: 12 MONTHS. |
| **Other Criteria** | PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PATIENT HAS NOT RECEIVED A PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# INAVOLISIB

## Products Affected

- ITOVEBI ORAL TABLET 3 MG, 9 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# INSULIN SUPPLIES PAYMENT DETERMINATION

### Products Affected

- 1ST TIER UNIFINE PENTP 5MM 31G
- 1ST TIER UNIFINE PNTIP 4MM 32G
- 1ST TIER UNIFINE PNTIP 6MM 31G
- 1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT
- 1ST TIER UNIFINE PNTP 29GX1/2"
- 1ST TIER UNIFINE PNTP 31GX3/16
- 1ST TIER UNIFINE PNTP 32GX5/32
- ABOUTTIME PEN NEEDLE
- ADVOCATE INS 0.3 ML 30GX5/16"
- ADVOCATE INS 0.3 ML 31GX5/16"
- ADVOCATE INS 0.5 ML 30GX5/16"
- ADVOCATE INS 0.5 ML 31GX5/16"
- ADVOCATE INS 1 ML 31GX5/16"
- ADVOCATE INS SYR 0.3 ML 29GX1/2
- ADVOCATE INS SYR 0.5 ML 29GX1/2
- ADVOCATE INS SYR 1 ML 29GX1/2"
- ADVOCATE INS SYR 1 ML 30GX5/16
- ADVOCATE PEN NDL 12.7MM 29G
- ADVOCATE PEN NEEDLE 32G 4MM
- ADVOCATE PEN NEEDLE 4MM 33G
- ADVOCATE PEN NEEDLES 5MM 31G
- ADVOCATE PEN NEEDLES 8MM 31G
- ALCOHOL 70% SWABS
- ALCOHOL PADS
- ALCOHOL PREP SWABS
- AQINJECT PEN NEEDLE 31G 5MM
- AQINJECT PEN NEEDLE 32G 4MM
- ASSURE ID DUO PRO NDL 31G 5MM
- ASSURE ID DUO-SHIELD 30GX3/16"
- ASSURE ID DUO-SHIELD 30GX5/16"
- ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"
- ASSURE ID PEN NEEDLE 30GX3/16"
- ASSURE ID PEN NEEDLE 30GX5/16"
- ASSURE ID PEN NEEDLE 31GX3/16"
- ASSURE ID PRO PEN NDL 30G 5MM
- ASSURE ID SYR 0.5 ML 29GX1/2" (RX)
- ASSURE ID SYR 0.5 ML 31GX15/64"
- ASSURE ID SYR 1 ML 31GX15/64"
- AUTOSHIELD DUO PEN NDL 30G 5MM
- BD AUTOSHIELD DUO NDL 5MMX30G
- BD ECLIPSE 30GX1/2" SYRINGE
- BD ECLIPSE NEEDLE 30GX1/2" (OTC)
- BD INS SYR 0.3 ML 8MMX31G(1/2)
- BD INS SYR UF 0.3 ML 12.7MMX30G
- BD INS SYR UF 0.5 ML 12.7MMX30G NOT FOR RETAIL SALE
- BD INS SYRNG UF 0.3 ML 8MMX31G
- BD INS SYRNG UF 0.5 ML 8MMX31G
- BD INSULIN SYR 1 ML 25GX1"
- BD INSULIN SYR 1 ML 25GX5/8"
- BD INSULIN SYR 1 ML 26GX1/2"
- BD INSULIN SYR 1 ML 27GX12.7MM
- BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE
- BD INSULIN SYRINGE SLIP TIP
- BD INSULIN SYRINGE U-500
- BD LUER-LOK SYRINGE 1 ML
- BD NANO 2 GEN PEN NDL 32G 4MM
- BD SAFETGLD INS 0.3 ML 29G 13MM
- BD SAFETGLD INS 0.5 ML 13MMX29G
- BD SAFETYGLD INS 0.3 ML 31G 8MM
- BD SAFETYGLD INS 0.5 ML 30G 8MM
- BD SAFETYGLD INS 1 ML 29G 13MM
- BD SAFETYGLID INS 1 ML 6MMX31G
- BD SAFETYGLIDE SYRINGE 27GX5/8
- BD SAFTYGLD INS 0.3 ML 6MMX31G
- BD SAFTYGLD INS 0.5 ML 29G 13MM
- BD SAFTYGLD INS 0.5 ML 6MMX31G
- BD SINGLE USE SWAB
- BD UF MICRO PEN NEEDLE 6MMX32G
- BD UF MINI PEN NEEDLE 5MMX31G
- BD UF NANO PEN NEEDLE 4MMX32G
- BD UF ORIG PEN NDL 12.7MMX29G
- BD UF SHORT PEN NEEDLE 8MMX31G
- BD VEO INS 0.3 ML 6MMX31G (1/2)
- BD VEO INS SYRING 1 ML 6MMX31G
- BD VEO INS SYRN 0.3 ML 6MMX31G
- BD VEO INS SYRN 0.5 ML 6MMX31G
- BORDERED GAUZE 2"X2"
- CAREFINE PEN NEEDLE 12.7MM 29G

- CAREFINE PEN NEEDLE 4MM 32G
- CAREFINE PEN NEEDLE 5MM 32G
- CAREFINE PEN NEEDLE 6MM 31G
- CAREFINE PEN NEEDLE 8MM 30G
- CAREFINE PEN NEEDLES 6MM 32G
- CAREFINE PEN NEEDLES 8MM 31G
- CARETOUCH ALCOHOL 70% PREP PAD
- CARETOUCH PEN NEEDLE 29G 12MM
- CARETOUCH PEN NEEDLE 31GX1/4"
- CARETOUCH PEN NEEDLE 31GX3/16"
- CARETOUCH PEN NEEDLE 31GX5/16"
- CARETOUCH PEN NEEDLE 32GX3/16"
- CARETOUCH PEN NEEDLE 32GX5/32"
- CARETOUCH SYR 0.3 ML 31GX5/16"
- CARETOUCH SYR 0.5 ML 30GX5/16"
- CARETOUCH SYR 0.5 ML 31GX5/16"
- CARETOUCH SYR 1 ML 28GX5/16"
- CARETOUCH SYR 1 ML 29GX5/16"
- CARETOUCH SYR 1 ML 30GX5/16"
- CARETOUCH SYR 1 ML 31GX5/16"
- CLICKFINE 31G X 5/16" NEEDLES 8MM, UNIVERSAL
- CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE
- CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND
- COMFORT EZ 0.3 ML 31G 15/64"
- COMFORT EZ 0.5 ML 31G 15/64"
- COMFORT EZ INS 0.3 ML 30GX1/2"
- COMFORT EZ INS 0.3 ML 30GX5/16"
- COMFORT EZ INS 1 ML 31G 15/64"
- COMFORT EZ INS 1 ML 31GX5/16"
- COMFORT EZ INSULIN SYR 0.3 ML
- COMFORT EZ INSULIN SYR 0.5 ML
- COMFORT EZ PEN NEEDLE 12MM 29G
- COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO
- COMFORT EZ PEN NEEDLES 4MM 33G
- COMFORT EZ PEN NEEDLES 5MM 31G MINI
- COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI
- COMFORT EZ PEN NEEDLES 5MM 33G
- COMFORT EZ PEN NEEDLES 6MM 31G
- COMFORT EZ PEN NEEDLES 6MM 32G
- COMFORT EZ PEN NEEDLES 6MM 33G
- COMFORT EZ PEN NEEDLES 8MM 31G SHORT
- COMFORT EZ PEN NEEDLES 8MM 32G
- COMFORT EZ PEN NEEDLES 8MM 33G
- COMFORT EZ PRO PEN NDL 30G 8MM
- COMFORT EZ PRO PEN NDL 31G 4MM
- COMFORT EZ PRO PEN NDL 31G 5MM
- COMFORT EZ SYR 0.3 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 28GX1/2"
- COMFORT EZ SYR 0.5 ML 29GX1/2"
- COMFORT EZ SYR 0.5 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 28GX1/2"
- COMFORT EZ SYR 1 ML 29GX1/2"
- COMFORT EZ SYR 1 ML 30GX1/2"
- COMFORT EZ SYR 1 ML 30GX5/16"
- COMFORT POINT PEN NDL 31GX1/3"
- COMFORT POINT PEN NDL 31GX1/6"
- COMFORT TOUCH PEN NDL 31G 4MM
- COMFORT TOUCH PEN NDL 31G 5MM
- COMFORT TOUCH PEN NDL 31G 6MM
- COMFORT TOUCH PEN NDL 31G 8MM
- COMFORT TOUCH PEN NDL 32G 4MM
- COMFORT TOUCH PEN NDL 32G 5MM
- COMFORT TOUCH PEN NDL 32G 6MM
- COMFORT TOUCH PEN NDL 32G 8MM
- COMFORT TOUCH PEN NDL 33G 4MM
- COMFORT TOUCH PEN NDL 33G 6MM
- COMFORT TOUCH PEN NDL 33GX5MM
- CURAD GAUZE PADS 2" X 2"
- CURITY ALCOHOL PREPS 2 PLY,MEDIUM
- CURITY GAUZE SPONGES (12 PLY)-200/BAG
- CURITY GUAZE PADS 1'S(12 PLY)
- DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII
- DERMACEA GAUZE 2"X2" SPONGE 8 PLY
- DERMACEA NON-WOVEN 2"X2" SPNGE
- DROPLET 0.3 ML 29G 12.7MM(1/2)
- DROPLET 0.3 ML 30G 12.7MM(1/2)
- DROPLET 0.5 ML 29GX12.5MM(1/2)
- DROPLET 0.5 ML 30GX12.5MM(1/2)
- DROPLET INS 0.3 ML 29GX12.5MM
- DROPLET INS 0.3 ML 30G 8MM(1/2)
- DROPLET INS 0.3 ML 30GX12.5MM
- DROPLET INS 0.3 ML 31G 6MM(1/2)

- DROPLET INS 0.3 ML 31G 8MM(1/2)
- DROPLET INS 0.5 ML 29G 12.7MM
- DROPLET INS 0.5 ML 30G 12.7MM
- DROPLET INS 0.5 ML 30GX6MM(1/2)
- DROPLET INS 0.5 ML 30GX8MM(1/2)
- DROPLET INS 0.5 ML 31GX6MM(1/2)
- DROPLET INS 0.5 ML 31GX8MM(1/2)
- DROPLET INS SYR 0.3 ML 30GX6MM
- DROPLET INS SYR 0.3 ML 30GX8MM
- DROPLET INS SYR 0.3 ML 31GX6MM
- DROPLET INS SYR 0.3 ML 31GX8MM
- DROPLET INS SYR 0.5 ML 30G 8MM
- DROPLET INS SYR 0.5 ML 31G 6MM
- DROPLET INS SYR 0.5 ML 31G 8MM
- DROPLET INS SYR 1 ML 29G 12.7MM
- DROPLET INS SYR 1 ML 30G 8MM
- DROPLET INS SYR 1 ML 30GX12.5MM
- DROPLET INS SYR 1 ML 30GX6MM
- DROPLET INS SYR 1 ML 31G 6MM
- DROPLET INS SYR 1 ML 31GX6MM
- DROPLET INS SYR 1 ML 31GX8MM
- DROPLET MICRON 34G X 9/64"
- DROPLET PEN NEEDLE 29G 10MM
- DROPLET PEN NEEDLE 29G 12MM
- DROPLET PEN NEEDLE 30G 8MM
- DROPLET PEN NEEDLE 31G 5MM
- DROPLET PEN NEEDLE 31G 6MM
- DROPLET PEN NEEDLE 31G 8MM
- DROPLET PEN NEEDLE 32G 4MM
- DROPLET PEN NEEDLE 32G 5MM
- DROPLET PEN NEEDLE 32G 6MM
- DROPLET PEN NEEDLE 32G 8MM
- DROPSAFE ALCOHOL 70% PREP PADS
- DROPSAFE INS SYR 0.3 ML 31G 6MM
- DROPSAFE INS SYR 0.3 ML 31G 8MM
- DROPSAFE INS SYR 0.5 ML 31G 6MM
- DROPSAFE INS SYR 0.5 ML 31G 8MM
- DROPSAFE INSUL SYR 1 ML 31G 6MM
- DROPSAFE INSUL SYR 1 ML 31G 8MM
- DROPSAFE INSULN 1 ML 29G 12.5MM
- DROPSAFE PEN NEEDLE 31GX1/4"
- DROPSAFE PEN NEEDLE 31GX3/16"
- DROPSAFE PEN NEEDLE 31GX5/16"
- DRUG MART ULTRA COMFORT SYR
- EASY CMFT SFTY PEN NDL 31G 5MM
- EASY CMFT SFTY PEN NDL 31G 6MM
- EASY CMFT SFTY PEN NDL 32G 4MM
- EASY COMFORT 0.3 ML 31G 1/2"
- EASY COMFORT 0.3 ML 31G 5/16"
- EASY COMFORT 0.3 ML SYRINGE
- EASY COMFORT 0.5 ML 30GX1/2"
- EASY COMFORT 0.5 ML 31GX5/16"
- EASY COMFORT 0.5 ML 32GX5/16"
- EASY COMFORT 0.5 ML SYRINGE
- EASY COMFORT 1 ML 31GX5/16"
- EASY COMFORT 1 ML 32GX5/16"
- EASY COMFORT ALCOHOL 70% PAD
- EASY COMFORT INSULIN 1 ML SYR
- EASY COMFORT PEN NDL 29G 4MM
- EASY COMFORT PEN NDL 29G 5MM
- EASY COMFORT PEN NDL 31GX1/4"
- EASY COMFORT PEN NDL 31GX3/16"
- EASY COMFORT PEN NDL 31GX5/16"
- EASY COMFORT PEN NDL 32GX5/32"
- EASY COMFORT PEN NDL 33G 4MM
- EASY COMFORT PEN NDL 33G 5MM
- EASY COMFORT PEN NDL 33G 6MM
- EASY COMFORT SYR 0.5 ML 29G 8MM
- EASY COMFORT SYR 1 ML 29G 8MM
- EASY COMFORT SYR 1 ML 30GX1/2"
- EASY GLIDE INS 0.3 ML 31GX6MM
- EASY GLIDE INS 0.5 ML 31GX6MM
- EASY GLIDE INS 1 ML 31GX6MM
- EASY GLIDE PEN NEEDLE 4MM 33G
- EASY TOUCH 0.3 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 27GX1/2"
- EASY TOUCH 0.5 ML SYR 29GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX1/2"
- EASY TOUCH 0.5 ML SYR 30GX5/16
- EASY TOUCH 1 ML SYR 27GX1/2"
- EASY TOUCH 1 ML SYR 29GX1/2"
- EASY TOUCH 1 ML SYR 30GX1/2"
- EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED
- EASY TOUCH FLIPLOK 1 ML 27GX0.5
- EASY TOUCH INSULIN 1 ML 29GX1/2
- EASY TOUCH INSULIN 1 ML 30GX1/2
- EASY TOUCH INSULIN SYR 0.3 ML
- EASY TOUCH INSULIN SYR 0.5 ML
- EASY TOUCH INSULIN SYR 1 ML
- EASY TOUCH INSULIN SYR 1 ML RETRACTABLE
- EASY TOUCH INSULN 1 ML 29GX1/2"
- EASY TOUCH INSULN 1 ML 30GX1/2"

- EASY TOUCH INSULN 1 ML 30GX5/16
- EASY TOUCH INSULN 1 ML 31GX5/16
- EASY TOUCH LUER LOK INSUL 1 ML
- EASY TOUCH PEN NEEDLE 29GX1/2"
- EASY TOUCH PEN NEEDLE 30GX5/16
- EASY TOUCH PEN NEEDLE 31GX1/4"
- EASY TOUCH PEN NEEDLE 31GX3/16
- EASY TOUCH PEN NEEDLE 31GX5/16
- EASY TOUCH PEN NEEDLE 32GX1/4"
- EASY TOUCH PEN NEEDLE 32GX3/16
- EASY TOUCH PEN NEEDLE 32GX5/32
- EASY TOUCH SAF PEN NDL 29G 5MM
- EASY TOUCH SAF PEN NDL 29G 8MM
- EASY TOUCH SAF PEN NDL 30G 5MM
- EASY TOUCH SAF PEN NDL 30G 8MM
- EASY TOUCH SYR 0.5 ML 28G 12.7MM
- EASY TOUCH SYR 0.5 ML 29G 12.7MM
- EASY TOUCH SYR 1 ML 27G 16MM
- EASY TOUCH SYR 1 ML 28G 12.7MM
- EASY TOUCH SYR 1 ML 29G 12.7MM
- EASY TOUCH UNI-SLIP SYR 1 ML
- EASYTOUCH SAF PEN NDL 30G 6MM
- EMBRACE PEN NEEDLE 29G 12MM
- EMBRACE PEN NEEDLE 30G 5MM
- EMBRACE PEN NEEDLE 30G 8MM
- EMBRACE PEN NEEDLE 31G 5MM
- EMBRACE PEN NEEDLE 31G 6MM
- EMBRACE PEN NEEDLE 31G 8MM
- EMBRACE PEN NEEDLE 32G 4MM
- EQL INSULIN 0.3 ML SYRINGE SHORT NEEDLE
- EQL INSULIN 0.5 ML SYRINGE SHORT NEEDLE
- EQL INSULIN 1 ML SYRINGE SHORT NEEDLE
- FIFTY50 INS SYR 1 ML 31GX5/16" SHORT NEEDLE (OTC)
- FIFTY50 PEN 31G X 3/16" NEEDLE (OTC)
- FP INSULIN 1 ML SYRINGE
- FREESTYLE PREC 0.5 ML 30GX5/16
- FREESTYLE PREC 0.5 ML 31GX5/16
- FREESTYLE PREC 1 ML 30GX5/16"
- FREESTYLE PREC 1 ML 31GX5/16"
- GAUZE PAD TOPICAL BANDAGE 2 X 2 "
- GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT
- GNP ULTRA COMFORT 0.5 ML SYR
- GNP ULTRA COMFORT 1 ML SYRINGE
- GNP ULTRA COMFORT 3/10 ML SYR
- HEALTHWISE INS 0.3 ML 30GX5/16"
- HEALTHWISE INS 0.3 ML 31GX5/16"
- HEALTHWISE INS 0.5 ML 30GX5/16"
- HEALTHWISE INS 0.5 ML 31GX5/16"
- HEALTHWISE INS 1 ML 30GX5/16"
- HEALTHWISE INS 1 ML 31GX5/16"
- HEALTHWISE PEN NEEDLE 31G 5MM
- HEALTHWISE PEN NEEDLE 31G 8MM
- HEALTHWISE PEN NEEDLE 32G 4MM
- HEALTHY ACCENTS PENTIP 4MM 32G
- HEALTHY ACCENTS PENTIP 5MM 31G
- HEALTHY ACCENTS PENTIP 6MM 31G
- HEALTHY ACCENTS PENTIP 8MM 31G
- HEALTHY ACCENTS PENTP 12MM 29G
- HEB INCONTROL ALCOHOL 70% PADS
- INCONTROL PEN NEEDLE 12MM 29G
- INCONTROL PEN NEEDLE 4MM 32G
- INCONTROL PEN NEEDLE 5MM 31G
- INCONTROL PEN NEEDLE 6MM 31G
- INCONTROL PEN NEEDLE 8MM 31G
- INSULIN SYR 0.3 ML 31GX1/4(1/2)
- INSULIN SYRIN 0.5 ML 28GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 29GX1/2" (OTC)
- INSULIN SYRIN 0.5 ML 30GX1/2" (RX)
- INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRING 0.5 ML 27G 1/2" INNER
- INSULIN SYRINGE 0.3 ML
- INSULIN SYRINGE 0.3 ML 31GX1/4
- INSULIN SYRINGE 0.5 ML
- INSULIN SYRINGE 0.5 ML 31GX1/4
- INSULIN SYRINGE 1 ML
- INSULIN SYRINGE 1 ML 27G 1/2" INNER
- INSULIN SYRINGE 1 ML 27G 16MM
- INSULIN SYRINGE 1 ML 28GX1/2" (OTC)
- INSULIN SYRINGE 1 ML 30GX1/2" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC)
- INSULIN SYRINGE 1 ML 31GX1/4"

- INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE
- INSUPEN 30G ULTRAFIN NEEDLE
- INSUPEN 31G ULTRAFIN NEEDLE
- INSUPEN 32G 6MM PEN NEEDLE
- INSUPEN 32G 8MM PEN NEEDLE
- INSUPEN PEN NEEDLE 29GX12MM
- INSUPEN PEN NEEDLE 31G 8MM
- INSUPEN PEN NEEDLE 31GX3/16"
- INSUPEN PEN NEEDLE 32GX4MM
- INSUPEN PEN NEEDLE 33GX4MM
- IV ANTISEPTIC WIPES
- KENDALL ALCOHOL 70% PREP PAD
- LISCO SPONGES 100/BAG
- LITE TOUCH 31GX1/4" PEN NEEDLE
- LITE TOUCH INSULIN 0.5 ML SYR
- LITE TOUCH INSULIN 1 ML SYR
- LITE TOUCH INSULIN SYR 1 ML
- LITE TOUCH PEN NEEDLE 29G
- LITE TOUCH PEN NEEDLE 31G
- LITETOUCH INS 0.3 ML 29GX1/2"
- LITETOUCH INS 0.3 ML 30GX5/16"
- LITETOUCH INS 0.3 ML 31GX5/16"
- LITETOUCH INS 0.5 ML 31GX5/16"
- LITETOUCH SYR 0.5 ML 28GX1/2"
- LITETOUCH SYR 0.5 ML 29GX1/2"
- LITETOUCH SYR 0.5 ML 30GX5/16"
- LITETOUCH SYRIN 1 ML 28GX1/2"
- LITETOUCH SYRIN 1 ML 29GX1/2"
- LITETOUCH SYRIN 1 ML 30GX5/16"
- MAGELLAN INSUL SYRINGE 0.3 ML
- MAGELLAN INSUL SYRINGE 0.5 ML
- MAGELLAN INSULIN SYR 0.3 ML
- MAGELLAN INSULIN SYR 0.5 ML
- MAGELLAN INSULIN SYRINGE 1 ML
- MAXI-COMFORT INS 0.5 ML 28G
- MAXI-COMFORT INS 1 ML 28GX1/2"
- MAXICOMFORT II PEN NDL 31GX6MM
- MAXICOMFORT INS 0.5 ML 27GX1/2"
- MAXICOMFORT INS 1 ML 27GX1/2"
- MAXICOMFORT PEN NDL 29G X 5MM
- MAXICOMFORT PEN NDL 29G X 8MM
- MICRODOT PEN NEEDLE 31GX6MM
- MICRODOT PEN NEEDLE 32GX4MM
- MICRODOT PEN NEEDLE 33GX4MM
- MICRODOT READYGARD NDL 31G 5MM OUTER
- MINI PEN NEEDLE 32G 4MM
- MINI PEN NEEDLE 32G 5MM
- MINI PEN NEEDLE 32G 6MM
- MINI PEN NEEDLE 32G 8MM
- MINI PEN NEEDLE 33G 4MM
- MINI PEN NEEDLE 33G 5MM
- MINI PEN NEEDLE 33G 6MM
- MINI ULTRA-THIN II PEN NDL 31G STERILE
- MONOJECT 0.5 ML SYRN 28GX1/2"
- MONOJECT 1 ML SYRN 27X1/2"
- MONOJECT 1 ML SYRN 28GX1/2" (OTC)
- MONOJECT INSUL SYR U100 (OTC)
- MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC)
- MONOJECT INSUL SYR U100 1 ML
- MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC)
- MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC)
- MONOJECT INSULIN SYR 0.3 ML
- MONOJECT INSULIN SYR 0.3 ML (OTC)
- MONOJECT INSULIN SYR 0.5 ML
- MONOJECT INSULIN SYR 0.5 ML (OTC)
- MONOJECT INSULIN SYR 1 ML 3'S (OTC)
- MONOJECT INSULIN SYR U-100
- MONOJECT SYRINGE 0.3 ML
- MONOJECT SYRINGE 0.5 ML
- MONOJECT SYRINGE 1 ML
- NANO 2 GEN PEN NEEDLE 32G 4MM
- NOVOFINE 30
- NOVOFINE 32G NEEDLES
- NOVOFINE PLUS PEN NDL 32GX1/6"
- NOVOTWIST
- PC UNIFINE PENTIPS 8MM NEEDLE SHORT
- PEN NEEDLE 30G 5MM OUTER
- PEN NEEDLE 30G 8MM INNER
- PEN NEEDLE 30G X 5/16"
- PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"
- PEN NEEDLES 12MM 29G 29GX12MM,STRL

- PEN NEEDLES 4MM 32G
- PEN NEEDLES 6MM 31G 31GX6MM, STRL
- PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC)
- PENTIPS PEN NEEDLE 29G 1/2"
- PENTIPS PEN NEEDLE 31G 1/4"
- PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM
- PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM
- PENTIPS PEN NEEDLE 32G 1/4"
- PENTIPS PEN NEEDLE 32GX5/32" 4MM
- PIP PEN NEEDLE 31G X 5MM
- PIP PEN NEEDLE 32G X 4MM
- PREVENT PEN NEEDLE 31GX1/4"
- PREVENT PEN NEEDLE 31GX5/16"
- PRO COMFORT 0.5 ML 30GX1/2"
- PRO COMFORT 0.5 ML 30GX5/16"
- PRO COMFORT 0.5 ML 31GX5/16"
- PRO COMFORT 1 ML 30GX1/2"
- PRO COMFORT 1 ML 30GX5/16"
- PRO COMFORT 1 ML 31GX5/16"
- PRO COMFORT ALCOHOL 70% PADS
- PRO COMFORT PEN NDL 31GX5/16"
- PRO COMFORT PEN NDL 32G X 1/4"
- PRO COMFORT PEN NDL 4MM 32G
- PRO COMFORT PEN NDL 5MM 32G
- PRODIGY INS SYR 1 ML 28GX1/2"
- PRODIGY SYRNG 0.5 ML 31GX5/16"
- PRODIGY SYRNGE 0.3 ML 31GX5/16"
- PURE CMFT SFTY PEN NDL 31G 5MM
- PURE CMFT SFTY PEN NDL 31G 6MM
- PURE CMFT SFTY PEN NDL 32G 4MM
- PURE COMFORT ALCOHOL 70% PADS
- PURE COMFORT PEN NDL 32G 4MM
- PURE COMFORT PEN NDL 32G 5MM
- PURE COMFORT PEN NDL 32G 6MM
- PURE COMFORT PEN NDL 32G 8MM
- RAYA SURE PEN NEEDLE 29G 12MM
- RAYA SURE PEN NEEDLE 31G 4MM
- RAYA SURE PEN NEEDLE 31G 5MM
- RAYA SURE PEN NEEDLE 31G 6MM
- RELI-ON INSULIN 0.5 ML SYR
- RELI-ON INSULIN 1 ML SYR
- RELION INS SYR 0.3 ML 31GX6MM
- RELION INS SYR 0.5 ML 31GX6MM
- RELION INS SYR 1 ML 31GX15/64"
- RELION MINI PEN 31G X 1/4" NDL
- SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10
- SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10
- SAFETY PEN NEEDLE 31G 4MM
- SAFETY PEN NEEDLE 5MM X 31G
- SAFETY SYRINGE 0.5 ML 30G 1/2"
- SECURESAFE PEN NDL 30GX5/16" OUTER
- SECURESAFE SYR 0.5 ML 29G 1/2" OUTER
- SECURESAFE SYRNG 1 ML 29G 1/2" OUTER
- SKY SAFETY PEN NEEDLE 30G 5MM
- SKY SAFETY PEN NEEDLE 30G 8MM
- SM ULT CFT 0.3 ML 31GX5/16(1/2)
- STERILE PADS 2" X 2"
- SURE CMFT SFTY PEN NDL 31G 6MM
- SURE CMFT SFTY PEN NDL 32G 4MM
- SURE COMFORT 0.5 ML SYRINGE
- SURE COMFORT 1 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE
- SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE
- SURE COMFORT 30G PEN NEEDLE
- SURE COMFORT ALCOHOL PREP PADS
- SURE COMFORT INS 0.3 ML 31GX1/4
- SURE COMFORT INS 0.5 ML 31GX1/4
- SURE COMFORT INS 1 ML 31GX1/4"
- SURE COMFORT PEN NDL 29GX1/2" 12.7MM
- SURE COMFORT PEN NDL 31G 5MM
- SURE COMFORT PEN NDL 31G 8MM
- SURE COMFORT PEN NDL 32G 4MM
- SURE COMFORT PEN NDL 32G 6MM
- SURE-FINE PEN NEEDLES 12.7MM
- SURE-FINE PEN NEEDLES 5MM
- SURE-FINE PEN NEEDLES 8MM
- SURE-JECT INSU SYR U100 0.3 ML

- SURE-JECT INSU SYR U100 0.5 ML
- SURE-JECT INSU SYR U100 1 ML
- SURE-JECT INSUL SYR U100 1 ML
- SURE-JECT INSULIN SYRINGE 1 ML
- SURE-PREP ALCOHOL PREP PADS
- TECHLITE 0.3 ML 29GX12MM (1/2)
- TECHLITE 0.3 ML 30GX8MM (1/2)
- TECHLITE 0.3 ML 31GX6MM (1/2)
- TECHLITE 0.3 ML 31GX8MM (1/2)
- TECHLITE 0.5 ML 30GX12MM (1/2)
- TECHLITE 0.5 ML 30GX8MM (1/2)
- TECHLITE 0.5 ML 31GX6MM (1/2)
- TECHLITE 0.5 ML 31GX8MM (1/2)
- TECHLITE INS SYR 1 ML 29GX12MM
- TECHLITE INS SYR 1 ML 30GX12MM
- TECHLITE INS SYR 1 ML 31GX6MM
- TECHLITE INS SYR 1 ML 31GX8MM
- TECHLITE PEN NEEDLE 29GX1/2"
- TECHLITE PEN NEEDLE 29GX3/8"
- TECHLITE PEN NEEDLE 31GX1/4"
- TECHLITE PEN NEEDLE 31GX3/16"
- TECHLITE PEN NEEDLE 31GX5/16"
- TECHLITE PEN NEEDLE 32GX1/4"
- TECHLITE PEN NEEDLE 32GX5/16"
- TECHLITE PEN NEEDLE 32GX5/32"
- TECHLITE PLUS PEN NDL 32G 4MM
- TERUMO INS SYRINGE U100-1 ML
- TERUMO INS SYRINGE U100-1/2 ML
- TERUMO INS SYRINGE U100-1/3 ML
- TERUMO INS SYRNG U100-1/2 ML
- THINPRO INS SYRIN U100-0.3 ML
- THINPRO INS SYRIN U100-0.5 ML
- THINPRO INS SYRIN U100-1 ML
- TOPCARE CLICKFINE 31G X 1/4"
- TOPCARE CLICKFINE 31G X 5/16"
- TOPCARE ULTRA COMFORT SYRINGE
- TRUE CMFRT PRO 0.5 ML 30G 5/16"
- TRUE CMFRT PRO 0.5 ML 31G 5/16"
- TRUE CMFRT PRO 0.5 ML 32G 5/16"
- TRUE CMFT SFTY PEN NDL 31G 5MM
- TRUE CMFT SFTY PEN NDL 31G 6MM
- TRUE CMFT SFTY PEN NDL 32G 4MM
- TRUE COMFORT 0.5 ML 30G 1/2"
- TRUE COMFORT 0.5 ML 30G 5/16"
- TRUE COMFORT 0.5 ML 31G 5/16"
- TRUE COMFORT 0.5 ML 31GX5/16"
- TRUE COMFORT 1 ML 31GX5/16"
- TRUE COMFORT ALCOHOL 70% PADS
- TRUE COMFORT PEN NDL 31G 8MM
- TRUE COMFORT PEN NDL 31GX5MM
- TRUE COMFORT PEN NDL 31GX6MM
- TRUE COMFORT PEN NDL 32G 5MM
- TRUE COMFORT PEN NDL 32G 6MM
- TRUE COMFORT PEN NDL 32GX4MM
- TRUE COMFORT PEN NDL 33G 4MM
- TRUE COMFORT PEN NDL 33G 5MM
- TRUE COMFORT PEN NDL 33G 6MM
- TRUE COMFORT PRO 1 ML 30G 1/2"
- TRUE COMFORT PRO 1 ML 30G 5/16"
- TRUE COMFORT PRO 1 ML 31G 5/16"
- TRUE COMFORT PRO 1 ML 32G 5/16"
- TRUE COMFORT PRO ALCOHOL PADS
- TRUE COMFORT SFTY 1 ML 30G 1/2"
- TRUE COMFRT PRO 0.5 ML 30G 1/2"
- TRUE COMFRT SFTY 1 ML 30G 5/16"
- TRUE COMFRT SFTY 1 ML 31G 5/16"
- TRUE COMFRT SFTY 1 ML 32G 5/16"
- TRUEPLUS PEN NEEDLE 29GX1/2"
- TRUEPLUS PEN NEEDLE 31G X 1/4"
- TRUEPLUS PEN NEEDLE 31GX3/16"
- TRUEPLUS PEN NEEDLE 31GX5/16"
- TRUEPLUS PEN NEEDLE 32GX5/32"
- TRUEPLUS SYR 0.3 ML 29GX1/2"
- TRUEPLUS SYR 0.3 ML 30GX5/16"
- TRUEPLUS SYR 0.3 ML 31GX5/16"
- TRUEPLUS SYR 0.5 ML 28GX1/2"
- TRUEPLUS SYR 0.5 ML 29GX1/2"
- TRUEPLUS SYR 0.5 ML 30GX5/16"
- TRUEPLUS SYR 0.5 ML 31GX5/16"
- TRUEPLUS SYR 1 ML 28GX1/2"
- TRUEPLUS SYR 1 ML 29GX1/2"
- TRUEPLUS SYR 1 ML 30GX5/16"
- TRUEPLUS SYR 1 ML 31GX5/16"
- ULTICAR INS 0.3 ML 31GX1/4(1/2)
- ULTICARE INS 1 ML 31GX1/4"
- ULTICARE INS SYR 0.3 ML 30G 8MM
- ULTICARE INS SYR 0.3 ML 31G 6MM
- ULTICARE INS SYR 0.3 ML 31G 8MM
- ULTICARE INS SYR 0.5 ML 31G 6MM
- ULTICARE INS SYR 0.5 ML 31G 8MM (OTC)
- ULTICARE INS SYR 1 ML 30GX1/2"
- ULTICARE PEN NEEDLE 31GX3/16"
- ULTICARE PEN NEEDLE 6MM 31G

- ULTICARE PEN NEEDLE 8MM 31G
- ULTICARE PEN NEEDLES 12MM 29G
- ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM
- ULTICARE PEN NEEDLES 6MM 32G
- ULTICARE SAFE PEN NDL 30G 8MM
- ULTICARE SAFE PEN NDL 5MM 30G
- ULTICARE SYR 0.3 ML 29G 12.7MM
- ULTICARE SYR 0.3 ML 30GX1/2"
- ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 0.5 ML 30GX1/2"
- ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL
- ULTICARE SYR 1 ML 31GX5/16"
- ULTIGUARD SAFE 1 ML 30G 12.7MM
- ULTIGUARD SAFE0.3 ML 30G 12.7MM
- ULTIGUARD SAFE0.5 ML 30G 12.7MM
- ULTIGUARD SAFEPACK 1 ML 31G 8MM
- ULTIGUARD SAFEPACK 29G 12.7MM
- ULTIGUARD SAFEPACK 31G 5MM
- ULTIGUARD SAFEPACK 31G 6MM
- ULTIGUARD SAFEPACK 31G 8MM
- ULTIGUARD SAFEPACK 32G 4MM
- ULTIGUARD SAFEPACK 32G 6MM
- ULTIGUARD SAFEPK 0.3 ML 31G 8MM
- ULTIGUARD SAFEPK 0.5 ML 31G 8MM
- ULTILET ALCOHOL STERL SWAB
- ULTILET INSULIN SYRINGE 0.3 ML
- ULTILET INSULIN SYRINGE 0.5 ML
- ULTILET INSULIN SYRINGE 1 ML
- ULTILET PEN NEEDLE
- ULTILET PEN NEEDLE 4MM 32G
- ULTRA COMFORT 0.3 ML SYRINGE
- ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G
- ULTRA COMFORT 0.5 ML 29GX1/2"
- ULTRA COMFORT 0.5 ML SYRINGE
- ULTRA COMFORT 1 ML 31GX5/16"
- ULTRA COMFORT 1 ML SYRINGE
- ULTRA FLO 0.3 ML 30G 1/2" (1/2)
- ULTRA FLO 0.3 ML 30G 5/16"(1/2)
- ULTRA FLO 0.3 ML 31G 5/16"(1/2)
- ULTRA FLO PEN NEEDLE 31G 5MM
- ULTRA FLO PEN NEEDLE 31G 8MM
- ULTRA FLO PEN NEEDLE 32G 4MM
- ULTRA FLO PEN NEEDLE 33G 4MM
- ULTRA FLO PEN NEEDLES 12MM 29G
- ULTRA FLO SYR 0.3 ML 29GX1/2"
- ULTRA FLO SYR 0.3 ML 30G 5/16"
- ULTRA FLO SYR 0.3 ML 31G 5/16"
- ULTRA FLO SYR 0.5 ML 29G 1/2"
- ULTRA THIN PEN NDL 32G X 4MM
- ULTRA-FINE 0.3 ML 30G 12.7MM
- ULTRA-FINE 0.3 ML 31G 6MM (1/2)
- ULTRA-FINE 0.3 ML 31G 8MM (1/2)
- ULTRA-FINE 0.5 ML 30G 12.7MM
- ULTRA-FINE INS SYR 1 ML 31G 8MM
- ULTRA-FINE PEN NDL 29G 12.7MM
- ULTRA-FINE PEN NEEDLE 32G 6MM
- ULTRA-FINE SYR 0.5 ML 31G 8MM
- ULTRA-FINE SYR 1 ML 30G 12.7MM
- ULTRA-THIN II 1 ML 31GX5/16"
- ULTRA-THIN II INS 0.3 ML 30G
- ULTRA-THIN II INS 0.3 ML 31G
- ULTRA-THIN II INS 0.5 ML 29G
- ULTRA-THIN II INS 0.5 ML 30G
- ULTRA-THIN II INS 0.5 ML 31G
- ULTRA-THIN II INS SYR 1 ML 29G
- ULTRA-THIN II INS SYR 1 ML 30G
- ULTRA-THIN II PEN NDL 29GX1/2"
- ULTRA-THIN II PEN NDL 31GX5/16
- ULTRACARE INS 0.3 ML 30GX5/16"
- ULTRACARE INS 0.3 ML 31GX5/16"
- ULTRACARE INS 0.5 ML 30GX1/2"
- ULTRACARE INS 0.5 ML 30GX5/16"
- ULTRACARE INS 0.5 ML 31GX5/16"
- ULTRACARE INS 1 ML 30G X 5/16"
- ULTRACARE INS 1 ML 30GX1/2"
- ULTRACARE INS 1 ML 31G X 5/16"
- ULTRACARE PEN NEEDLE 31GX1/4"
- ULTRACARE PEN NEEDLE 31GX3/16"
- ULTRACARE PEN NEEDLE 31GX5/16"
- ULTRACARE PEN NEEDLE 32GX1/4"
- ULTRACARE PEN NEEDLE 32GX3/16"
- ULTRACARE PEN NEEDLE 32GX5/32"
- ULTRACARE PEN NEEDLE 33GX5/32"
- UNIFINE OTC PEN NEEDLE 31G 5MM
- UNIFINE OTC PEN NEEDLE 32G 4MM
- UNIFINE PEN NEEDLE 32G 4MM
- UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL
- UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI

- UNIFINE PENTIPS 32GX1/4"
- UNIFINE PENTIPS 32GX5/32" 32GX4MM, STRL, NANO
- UNIFINE PENTIPS 33GX5/32"
- UNIFINE PENTIPS 6MM 31G
- UNIFINE PENTIPS MAX 30GX3/16"
- UNIFINE PENTIPS NEEDLES 29G
- UNIFINE PENTIPS PLUS 29GX1/2" 12MM
- UNIFINE PENTIPS PLUS 30GX3/16"
- UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM
- UNIFINE PENTIPS PLUS 31GX3/16" MINI
- UNIFINE PENTIPS PLUS 31GX5/16" SHORT
- UNIFINE PENTIPS PLUS 32GX5/32"
- UNIFINE PENTIPS PLUS 33GX5/32"
- UNIFINE PROTECT 30G 5MM
- UNIFINE PROTECT 30G 8MM
- UNIFINE PROTECT 32G 4MM
- UNIFINE SAFECONTROL 30G 5MM
- UNIFINE SAFECONTROL 30G 8MM
- UNIFINE SAFECONTROL 31G 5MM
- UNIFINE SAFECONTROL 31G 6MM
- UNIFINE SAFECONTROL 31G 8MM
- UNIFINE SAFECONTROL 32G 4MM
- UNIFINE ULTRA PEN NDL 31G 5MM
- UNIFINE ULTRA PEN NDL 31G 6MM
- UNIFINE ULTRA PEN NDL 31G 8MM
- UNIFINE ULTRA PEN NDL 32G 4MM
- VANISHPOINT 0.5 ML 30GX1/2" SY OUTER
- VANISHPOINT INS 1 ML 30GX3/16"
- VANISHPOINT U-100 29X1/2 SYR
- VERIFINE INS SYR 1 ML 29G 1/2"
- VERIFINE PEN NEEDLE 29G 12MM
- VERIFINE PEN NEEDLE 31G 5MM
- VERIFINE PEN NEEDLE 31G X 6MM
- VERIFINE PEN NEEDLE 31G X 8MM
- VERIFINE PEN NEEDLE 32G 6MM
- VERIFINE PEN NEEDLE 32G X 4MM
- VERIFINE PEN NEEDLE 32G X 5MM
- VERIFINE PLUS PEN NDL 31G 5MM
- VERIFINE PLUS PEN NDL 31G 8MM
- VERIFINE PLUS PEN NDL 32G 4MM
- VERIFINE PLUS PEN NDL 32G 4MM-SHARPS CONTAINER
- VERIFINE SYRING 0.5 ML 29G 1/2"
- VERIFINE SYRING 1 ML 31G 5/16"
- VERIFINE SYRNG 0.3 ML 31G 5/16"
- VERIFINE SYRNG 0.5 ML 31G 5/16"
- VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY
- WEBCOL ALCOHOL PREPS 20'S,LARGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | LIFETIME |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | ONLY COVERED UNDER PART D WHEN USED CONCURRENTLY WITH INSULIN. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# INTERFERON FOR MS-AVONEX

### Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- AVONEX PEN 30 MCG/0.5 ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# INTERFERON FOR MS-BETASERON

## Products Affected

- BETASERON SUBCUTANEOUS KIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# INTERFERON GAMMA-1B

## Products Affected

- ACTIMMUNE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPETROSIS (SMO): PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST OR HEMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | RENEWAL: CGD, SMO: 1) DEMONSTRATED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED HEMATOPOIETIC CELL TRANSPLANTATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ITRACONAZOLE SOLUTION

## Products Affected

- *itraconazole oral solution*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 MONTHS |
| **Other Criteria** | ESOPHAGEAL CANDIDIASIS AND OROPHARYNGEAL CANDIDIASIS: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IVACAFTOR

## Products Affected

- KALYDECO ORAL GRANULES IN PACKET 25 MG, 5.8 MG, 50 MG, 75 MG
- KALYDECO ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT |
| **Coverage Duration** | INITIAL: 12 MONTHS. RENEWAL: LIFETIME |
| **Other Criteria** | CF: INITIAL: NOT HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE. RENEWAL: 1) MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR 2) REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IVERMECTIN

## Products Affected

- *ivermectin oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Prevention or treatment of COVID-19 |
| **Required Medical Information** | Diagnosis of one of the following: A.) Strongyloidiasis of the intestinal tract or B.) Onchocerciasis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 month |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IVOSIDENIB

## Products Affected

- TIBSOVO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IWILFIN

## Products Affected

- IWILFIN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of high-risk neuroblastoma to be used to reduce the risk of relapse in adult and pediatric patients who have demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IXAZOMIB

## Products Affected

- NINLARO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LANADELUMAB

## Products Affected

- TAKHZYRO SUBCUTANEOUS SOLUTION MG/ML)
- TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML (150

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | HEREDITARY ANGIOEDEMA (HAE): INITIAL: DIAGNOSIS CONFIRMED BY COMPLEMENT TESTING. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HAE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | HAE: INITIAL: NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. RENEWAL: 1) IMPROVEMENT COMPARED TO BASELINE IN HAE ATTACKS (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY), AND 2) NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE ATTACKS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LAPATINIB

## Products Affected

- *lapatinib*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LAROTRECTINIB

## Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | APPROVAL FOR VITRAKVI ORAL SOLUTION: TRIAL OF VITRAKVI CAPSULES OR PATIENT IS UNABLE TO TAKE CAPSULE FORMULATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LAZERTINIB

## Products Affected

- LAZCLUZE ORAL TABLET 240 MG, 80 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LEDIPASVIR-SOFOSBUVIR

## Products Affected

- HARVONI ORAL PELLETS IN PACKET
  33.75-150 MG, 45-200 MG
- *ledipasvir-sofosbuvir*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | HCV RNA LEVEL WITHIN PAST 6 MONTHS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. |
| **Other Criteria** | 1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, AND 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, TIPRANAVIR/RITONAVIR, SOFOSBUVIR (AS A SINGLE AGENT), EPCLUSA, ZEPATIER, MAVYRET, OR VOSEVI. REQUESTS FOR HARVONI 45MG-200MG PELLETS: PATIENT IS UNABLE TO SWALLOW TABLETS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LENALIDOMIDE

## Products Affected

- *lenalidomide*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LENVATINIB

## Products Affected

- LENVIMA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LETERMOVIR

## Products Affected

- PREVYMIS ORAL PELLETS IN PACKET
- PREVYMIS ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 4 MONTHS |
| **Other Criteria** | NONE |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LEUPROLIDE

## Products Affected

- *leuprolide subcutaneous kit*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | NONE |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | BVD DETERMINATION AS REQUIRED PER CMS GUIDANCE |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LEUPROLIDE DEPOT

## Products Affected

- *leuprolide (3 month)*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LEUPROLIDE-ELIGARD

## Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS. |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LEUPROLIDE-LUPRON DEPOT

### Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST. |
| **Coverage Duration** | PROSTATE CA: 12 MOS. UTERINE FIBROIDS: 3 MOS. ENDOMETRIOSIS: INITIAL/RENEWAL: 6 MOS. |
| **Other Criteria** | INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. RENEWAL: ENDOMETRIOSIS: 1) IMPROVEMENT OF PAIN RELATED TO ENDOMETRIOSIS WHILE ON THERAPY, 2) RECEIVING CONCOMITANT ADD-BACK THERAPY (I.E., COMBINATION ESTROGEN-PROGESTIN OR PROGESTIN-ONLY CONTRACEPTIVE PREPARATION), 3) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, AND 4) HAS NOT RECEIVED A TOTAL OF 12 MONTHS OF TREATMENT PER LIFETIME. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# LEVODOPA

## Products Affected

- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PARKINSONS DISEASE (PD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# L-GLUTAMINE

## Products Affected

- ENDARI
- *glutamine (sickle cell)*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | SICKLE CELL DISEASE(SCD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST |
| **Coverage Duration** | INITIAL: 12 MONTHS. RENEWAL: LIFETIME. |
| **Other Criteria** | SCD: INITIAL: PATIENTS 18 YEARS OR OLDER: ONE OF THE FOLLOWING: 1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, 2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR 3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME. PATIENTS 5 TO 17 YEARS: APPROVED WITHOUT ADDITIONAL CRITERIA. RENEWAL: HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LIDOCAINE

## Products Affected

- *lidocaine hcl mucous membrane solution 4 % (40 mg/ml)*
- *lidocaine topical adhesive patch,medicated 5 %*
- *lidocaine topical ointment*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION. |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LIDOCAINE PRILOCAINE

## Products Affected

- *lidocaine-prilocaine topical cream*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION. |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LORLATINIB

## Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LOTILANER

## Products Affected

- XDEMVY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | DEMODEX BLEPHARITIS: 18 YEARS OF AGE OR OLDER |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 WEEKS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# LUMACAFTOR-IVACAFTOR

### Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: CYSTIC FIBROSIS (CF): CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CF. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CF EXPERT. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: LIFETIME. |
| **Other Criteria** | CF: RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MACITENTAN

## Products Affected

- OPSUMIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: 1) DOCUMENTED CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) OF 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | PAH: RENEWAL: 1) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE, OR 2) A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MARIBAVIR

## Products Affected

- LIVTENCITY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MEPOLIZUMAB

### Products Affected

- NUCALA SUBCUTANEOUS AUTO-INJECTOR
- NUCALA SUBCUTANEOUS RECON SOLN
- NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. NASAL POLYPS: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. |
| **Coverage Duration** | INITIAL: ASTHMA: 4 MO. NASAL POLYPS: 6 MO. OTHERS: 12 MO. RENEWAL: NASAL POLYPS, ASTHMA: 12 MO. |
| **Other Criteria** | NONE |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# METHYLNALTREXONE

### Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | ADVANCED ILLNESS: OPIOID-INDUCED CONSTIPATION. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 MONTHS FOR PATIENTS RECEIVING PALLIATIVE CARE, 12 MONTHS FOR CHRONIC, NON-CANCER PAIN. |
| **Other Criteria** | ADVANCED ILLNESS: PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# METHYLNALTREXONE ORAL

## Products Affected

- RELISTOR ORAL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | OPIOID INDUCED CONSTIPATION WITH CHRONIC NON-CANCER PAIN: 1) HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS, AND 2) TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MIDOSTAURIN

## Products Affected

- RYDAPT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MIFEPRISTONE

## Products Affected

- *mifepristone oral tablet 300 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CUSHINGS SYNDROME (CS): INITIAL: DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) 24-HR URINE FREE CORTISOL (2 OR MORE TESTS TO CONFIRM), 2) OVERNIGHT 1MG DEXAMETHASONE TEST, OR 3) LATE NIGHT SALIVARY CORTISOL (2 OR MORE TESTS TO CONFIRM). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CS: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST. |
| **Coverage Duration** | INITIAL AND RENEWAL: 12 MONTHS. |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MIGALASTAT

## Products Affected

- GALAFOLD

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | FABRY DISEASE: INITIAL: PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | FABRY DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS. |
| **Coverage Duration** | INITIAL: 6 MOS. RENEWAL: 12 MOS. |
| **Other Criteria** | FABRY DISEASE: INITIAL: NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME), RENEWAL: 1) PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION, AND 2) NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MIGLUSTAT

## Products Affected

- *miglustat*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MILTEFOSINE

## Products Affected

- IMPAVIDO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# MIRDAMETINIB

## Products Affected

- GOMEKLI ORAL CAPSULE 1 MG, 2 MG
- GOMEKLI ORAL TABLET FOR SUSPENSION

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# NAFARELIN

## Products Affected

- SYNAREL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: ENDOMETRIOSIS: DIAGNOSIS IS CONFIRMED VIA SURGICAL OR DIRECT VISUALIZATION (E.G., PELVIC ULTRASOUND) OR HISTOPATHOLOGICAL CONFIRMATION (E.G., LAPAROSCOPY OR LAPAROTOMY) IN THE LAST 10 YEARS. CENTRAL PRECOCIOUS PUBERTY (CPP): FEMALES: ELEVATED LEVELS OF FOLLICLE-STIMULATING HORMONE (FSH) GREATER THAN 4.0 MIU/ML AND LUTEINIZING HORMONE (LH) LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. MALES: ELEVATED LEVELS OF FSH GREATER THAN 5.0 MIU/ML AND LH LEVEL GREATER THAN 0.2 TO 0.3 MIU/ML AT DIAGNOSIS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: ENDOMETRIOSIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST. CPP: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST. |
| **Coverage Duration** | ENDOMETRIOSIS: 6 MONTHS. CPP: INITIAL/RENEWAL: 12 MONTHS. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: ENDOMETRIOSIS: 1) NO CONCURRENT USE WITH ANOTHER GNRH-MODULATING AGENT, 2) TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION, AND 3) HAS NOT RECEIVED A TOTAL OF 6 MONTHS OF TREATMENT PER LIFETIME. CPP: FEMALES: 1) YOUNGER THAN 8 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR BREAST DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). MALES: 1) YOUNGER THAN 9 YEARS OF AGE AT ONSET OF CPP, AND 2) DOCUMENTATION OF PUBERTAL STAGING USING THE TANNER SCALE FOR GENITAL DEVELOPMENT (STAGE 2 OR ABOVE) AND PUBIC HAIR GROWTH (STAGE 2 OR ABOVE). RENEWAL: CPP: 1) TANNER SCALE STAGING AT INITIAL DIAGNOSIS OF CPP HAS STABILIZED OR REGRESSED DURING THREE SEPARATE MEDICAL VISITS IN THE PREVIOUS YEAR, AND 2) HAS NOT REACHED ACTUAL AGE WHICH CORRESPONDS TO CURRENT PUBERTAL AGE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# NARCOLEPSY AGENTS

## Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# NERATINIB MALEATE

## Products Affected

- NERLYNX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | EARLY-STAGE (STAGE I-III) BREAST CANCER: MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE. ALL OTHER FDA APPROVED INDICATIONS ARE COVERED WITHOUT ADDITIONAL CRITERIA, EXCEPT THOSE CRITERIA IN THE FDA APPROVED LABEL. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# NILOTINIB

## Products Affected

- DANZITEN
- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# NINTEDANIB

## Products Affected

- OFEV

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of one of the following A.) Idiopathic pulmonary fibrosis (IPF), B.) Systemic sclerosis-associated interstitial lung disease (ILD), or C.) Chronic fibrosing interstitial lung disease with a progressive phenotype |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# NIRAPARIB

## Products Affected

- ZEJULA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER: 1) ZEJULA WILL BE USED AS MONOTHERAPY, AND 2) ZEJULA IS STARTED NO LATER THAN 8 WEEKS AFTER THE MOST RECENT PLATINUM-CONTAINING REGIMEN. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# NITISINONE

## Products Affected

- *nitisinone oral capsule 10 mg, 2 mg, 5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | HEREDITARY TYROSINEMIA TYPE 1 (HT-1): INITIAL: DIAGNOSIS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE. RENEWAL: URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HT-1: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# OFATUMUMAB-SQ

## Products Affected

- KESIMPTA PEN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# OGSIVEO

## Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of progressing desmoid tumors who require systemic treatment |
| **Age Restrictions** | 18 years or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# OJEMDA

## Products Affected

- OJEMDA ORAL SUSPENSION FOR RECONSTITUTION
- OJEMDA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of relapsed or refractory pediatric low-grade glioma harboring a BRAF fusion or rearrangement, or BRAF V600 mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# OJJAARA

## Products Affected

- OJJAARA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF [postpolycythemia vera (PV) and post-essential thrombocythemia (ET)], in adults with anemia. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# OLANZAPINE/SAMIDORPHAN

## Products Affected

- LYBALVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | SCHIZOPHRENIA/BIPOLAR I: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | SCHIZOPHRENIA: (1) PATIENT IS AT HIGH RISK OF WEIGHT GAIN AND (2) TRIAL OF OR CONTRAINDICATION TO LATUDA OR ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE. BIPOLAR I: (1) PATIENT IS AT HIGH RISK OF WEIGHT GAIN AND (2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING ORAL ANTIPSYCHOTICS: RISPERIDONE, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# OLAPARIB

## Products Affected

- LYNPARZA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | NONE |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# OLUTASIDENIB

## Products Affected

- REZLIDHIA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# OMALIZUMAB

## Products Affected

- XOLAIR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: ASTHMA: POSITIVE SKIN PRICK OR BLOOD TEST (E.G., ELISA, FEIA) TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL AND RENEWAL: CHRONIC IDIOPATHIC URTICARIA (CIU): PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY. INITIAL: NASAL POLYPS: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. |
| **Coverage Duration** | 12 MONTHS |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: CIU: TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE AND STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK. NASAL POLYPS: 1) PREVIOUS 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE PREFERRED AGENT: NUCALA, DUPIXENT. ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, 3) NOT CONCURRENTLY RECEIVING DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. RENEWAL: CIU: DIAGNOSIS OF CIU. NASAL POLYPS: CLINICAL BENEFIT COMPARED TO BASELINE. ASTHMA: 1) NOT CONCURRENTLY RECEIVING DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA- |
| | RELATED SYMPTOMS, OR D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# OSIMERTINIB

## Products Affected

- TAGRISSO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | EGFR EXON 19 DELETIONS OR EXON 21 L858R MUTATIONS NON-SMALL CELL LUNG CANCER (NSCLC) AND METASTATIC NSCLC WITH EGFR T790M MUTATION: NOT ON CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PACRITINIB

## Products Affected

- VONJO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PALBOCICLIB

## Products Affected

- IBRANCE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PASIREOTIDE DIASPARTATE

## Products Affected

- SIGNIFOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CUSHINGS DISEASE (CD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |
| **Other Criteria** | CD: RENEWAL: 1) CONTINUED IMPROVEMENT OF CUSHINGS DISEASE, AND 2) MAINTAINED TOLERABILITY TO SIGNIFOR. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PAZOPANIB

## Products Affected

- *pazopanib*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | ADVANCED SOFT TISSUE SARCOMA (STS): NOT USED FOR ADIPOCYTIC STS OR GASTROINTESTINAL STROMAL TUMORS (GIST) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

### Products Affected

- *alyq*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Any of the following A.) Nitrate therapy, including intermittent use, B.) Concomitant use with riocguat or other guanylate cyclase stimulators, C.) Concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/tenofovir/emtricitabine |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension (WHO Group I), confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST. THIS CRITERIA DOES NOT APPLY TO SILDENAFIL FOR AGES 1 TO 17 YEARS. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS |
| **Other Criteria** | NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PEGFILGRASTIM

## Products Affected

- NEULASTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | NON MYELOID MALIGNANCY, ACUTE RADIATION EXPOSURE: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | NON MYELOID MALIGNANCY: TRIAL OF OR CONTRAINDICATION TO NYVEPRIA. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PEGFILGRASTIM - APGF

## Products Affected

- NYVEPRIA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | NON MYELOID MALIGNANCY: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PEGFILGRASTIM - CBQV

## Products Affected

- UDENYCA
- UDENYCA AUTOINJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | NON MYELOID MALIGNANCY: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | NON MYELOID MALIGNANCY: TRIAL OF OR CONTRAINDICATION TO NYVEPRIA. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PEGFILGRASTIM - JMDB

## Products Affected

- FULPHILA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | NON MYELOID MALIGNANCY: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | NON MYELOID MALIGNANCY: TRIAL OF OR CONTRAINDICATION TO NYVEPRIA |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PEGVISOMANT

## Products Affected

- SOMAVERT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PEMIGATINIB

## Products Affected

- PEMAZYRE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PENICILLAMINE

## Products Affected

- *penicillamine oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: WILSONS DISEASE: CONFIRMED BY ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN IS LESS THAN 20MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: PATIENT HAS NEPHROLITHIASIS AND ONE OR MORE OF THE FOLLOWING: 1) STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, 2) IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, OR 3) POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. |
| **Coverage Duration** | INITIAL: 12 MONTHS, RENEWAL: LIFETIME. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: WILSONS DISEASE: 1) KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE, AND 2) REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRE A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN). CYSTINURIA: REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRES A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN) AND A FORMULARY VERSION OF TIOPRONIN (THIOLA)/THIOLA EC. RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, 2) TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED, AND 3) REQUESTS FOR FORMULARY VERSION OF PENICILLAMINE CAPSULE REQUIRES A TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE TABLET (DEPEN). RENEWAL: RA: 1) NO HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY, 2) EXPERIENCED OR MAINTAINED IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT COMPARED TO BASELINE. WILSONS DISEASE, CYSTINURIA: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PIMAVANSERIN

## Products Affected

- NUPLAZID

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | PSYCHOSIS IN PARKINSONS DISEASE (PD): INITIAL: 18 YEARS OR OLDER |
| **Prescriber Restrictions** | PSYCHOSIS IN PD: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (E.G., PSYCHIATRIST). |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | PSYCHOSIS IN PD: RENEWAL: IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PIRFENIDONE

## Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 534 mg, 801 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis of idiopathic pulmonary fibrosis |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a pulmonologist |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PIRTOBRUTINIB

## Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# POMALIDOMIDE

## Products Affected

- POMALYST

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PONATINIB

## Products Affected

- ICLUSIG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | CML: MUTATIONAL ANALYSIS PRIOR TO INITIATION AND ICLUSIG IS APPROPRIATE PER NCCN GUIDELINE TABLE FOR TREATMENT RECOMMENDATIONS BASED ON BCR-ABL1 MUTATION PROFILE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# POSACONAZOLE

## Products Affected

- *posaconazole oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | OROPHARYNGEAL CANDIDIASIS (OPC): 3 MONTHS. PROPHYLAXIS: 6 MONTHS. TREATMENT: 12 WEEKS. |
| **Other Criteria** | NONE |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# POSACONAZOLE-POWDERMIX

## Products Affected

- NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 MONTHS |
| **Other Criteria** | PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTION: INABILITY TO SWALLOW TABLETS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PRALSETINIB

## Products Affected

- GAVRETO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# PYRIMETHAMINE

## Products Affected

- *pyrimethamine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | TOXOPLASMOSIS: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST. |
| **Coverage Duration** | TOXOPLASMOSIS: INITIAL: 8 WEEKS, RENEWAL: 6 MOS. |
| **Other Criteria** | TOXOPLASMOSIS: RENEWAL: ONE OF THE FOLLOWING: (1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING), OR (2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENTLY TAKING AN ANTI-RETROVIRAL THERAPY IF HIV POSITIVE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# QUININE

## Products Affected

- *quinine sulfate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# REGORAFENIB

## Products Affected

- STIVARGA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RELUGOLIX

## Products Affected

- ORGOVYX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# REPOTRECTINIB

## Products Affected

- AUGTYRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# REVUMENIB

## Products Affected

- REVUFORJ

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RIBOCICLIB

### Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | ADVANCED OR METASTATIC BREAST CANCER: TRIAL OF OR CONTRAINDICATION TO VERZENIO OR IBRANCE WHERE INDICATIONS ALIGN. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RIFAXIMIN

## Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | TRAVELERS DIARRHEA/HE: 12 MOS. IBS-D: 8 WKS. |
| **Other Criteria** | RIFAXIMIN 550 MG TABLETS: HE: TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RIMEGEPANT

## Products Affected

- NURTEC ODT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: ACUTE MIGRAINE TREATMENT: TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN). EPISODIC MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: ACUTE MIGRAINE TREATMENT: 1) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR 2) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS. EPISODIC MIGRAINE PREVENTION: 1) NO CONCURRENT USE WITH OTHER CGRP INHIBITORS FOR MIGRAINE PREVENTION, AND 2) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH THERAPY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# RIOCIGUAT

## Products Affected

- ADEMPAS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) II-IV SYMPTOMS. PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4: NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: PAH, CTEPH: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST. |
| **Coverage Duration** | INITIAL AND RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: PAH: NOT CONCURRENTLY TAKING NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. CTEPH: 1) NOT CONCURRENTLY TAKING NITRATES, NITRIC OXIDE DONORS, OR ANY PDE INHIBITORS, AND 2) NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL: PAH, CTEPH: 1) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS, AND 2) NOT CONCURRENTLY TAKING NITRATES, NITRIC OXIDE DONORS, PHOSPHODIESTERASE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. |

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RIPRETINIB

## Products Affected

- QINLOCK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RISANKIZUMAB-RZAA

### Products Affected

- SKYRIZI SUBCUTANEOUS PEN INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)
- SKYRIZI SUBCUTANEOUS SYRINGE
- SKYRIZI SUBCUTANEOUS WEARABLE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). CD: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# ROPEGINTERFERON ALFA-2B-NJFT

## Products Affected

- BESREMI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RUCAPARIB

## Products Affected

- RUBRACA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: ONE OF THE FOLLOWING: 1) RECEIVED A BILATERAL ORCHIECTOMY, 2) CASTRATE LEVEL OF TESTOSTERONE (I.E., LESS THAN 50 NG/DL), OR 3) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# RUXOLITINIB

## Products Affected

- JAKAFI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS. |
| **Other Criteria** | MYELOFIBROSIS: RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SAPROPTERIN

## Products Affected

- *javygtor oral tablet,soluble*
- *sapropterin oral tablet,soluble*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | HYPERPHENYLALANINEMIA (HPA): INITIAL: NOT CONCURRENTLY USING PALYNZIQ. RENEWAL: 1) CONTINUES TO BENEFIT FROM TREATMENT, AND 2) NOT CONCURRENTLY USING PALYNZIQ. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SARILUMAB

## Products Affected

- KEVZARA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | RHEUMATOID ARTHRITIS (RA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | RA: INITIAL: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SECUKINUMAB

### Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG). AS, NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). ERA: TRIAL OF OR CONTRAINDICATION TO ONE NSAID, SULFASALAZINE, OR METHOTREXATE. RENEWAL: PSO, PSA, AS, NR-AXSPA, ERA: CONTINUES TO BENEFIT FROM THE MEDICATION. |

| PA Criteria | Criteria Details |
|---|---|
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SELEXIPAG

### Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLETS,DOSE PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | PULMONARY ARTERIAL HYPERTENSION (PAH): INITIAL: 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION WITH THE FOLLOWING PARAMETERS: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) II-IV SYMPTOMS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | PAH: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS |
| **Other Criteria** | PAH: INITIAL: WHO FC II-III SYMPTOMS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS, EACH FROM A DIFFERENT DRUG CLASS: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIAN RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR, OR 3) FORMULARY VERSION OF AN ORAL CGMP STIMULATOR. WHO FC III SYMPTOMS AND EVIDENCE OF RAPID PROGRESSION OR POOR PROGNOSIS, WHO FC IV SYMPTOMS: NO STEP. RENEWAL: 1) IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST, OR 2) REMAINED STABLE FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST AND WHO FC HAS IMPROVED OR REMAINED STABLE. |
| **Indications** | All FDA-approved Indications. |

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SELINEXOR

## Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SELPERCATINIB

## Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SELUMETINIB

## Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SIPONIMOD

## Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER(FOR 1MG MAINT)
- MAYZENT STARTER(FOR 2MG MAINT)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | MULTIPLE SCLEROSIS: RENEWAL: 1) DEMONSTRATION OF CLINICAL BENEFIT COMPARED TO PRE-TREATMENT BASELINE AND 2) DOES NOT HAVE LYMPHOPENIA. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SODIUM OXYBATE

## Products Affected

- *sodium oxybate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: ALL INDICATIONS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE. |
| **Coverage Duration** | INITIAL 6 MONTHS. RENEWAL: 12 MONTHS |
| **Other Criteria** | INITIAL: EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: 1) NOT CURRENTLY TAKING A SEDATIVE HYPNOTIC AGENT, 2) FOR PATIENTS 18 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO THE FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, PITOLISANT OR SOLRIAMFETOL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY, AND 3) FOR PATIENTS 7 TO 17 YEARS OF AGE: TRIAL OF OR CONTRAINDICATION TO ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY. CATAPLEXY IN NARCOLEPSY: NOT CURRENTLY TAKING A SEDATIVE HYPNOTIC AGENT. RENEWAL (ALL INDICATIONS): 1) SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE, AND 2) NOT CURRENTLY TAKING A SEDATIVE HYPNOTIC AGENT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SOFOSBUVIR/VELPATASVIR

## Products Affected

- EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG
- EPCLUSA ORAL TABLET 200-50 MG
- *sofosbuvir-velpatasvir*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | HCV RNA LEVEL WITHIN PAST 6 MONTHS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. |
| **Other Criteria** | 1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR, TOPOTECAN, SOVALDI (AS A SINGLE AGENT), HARVONI, ZEPATIER, MAVYRET, OR VOSEVI, AND 3) PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

## Products Affected

- VOSEVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | HCV RNA LEVEL WITHIN PAST 6 MONTHS |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. |
| **Other Criteria** | 1) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE, 2) NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR, TIPRANAVIR/RITONAVIR, SOVALDI (AS A SINGLE AGENT), EPCLUSA, HARVONI, ZEPATIER, OR MAVYRET, AND 3) DOES NOT HAVE MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SOMATROPIN - NORDITROPIN

## Products Affected

- NORDITROPIN FLEXPRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. |
| **Required Medical Information** | INITIAL: PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. RENEWAL: PEDIATRIC GHD: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND OR PATIENT HAS NOT COMPLETED PREPUBERTALGROWTH. ISS, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES AS CONFIRMED BY RADIOGRAPH OF THE WRIST AND HAND. PWS: IMPROVEMENT IN BODY COMPOSITION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SOMATROPIN - SEROSTIM

## Products Affected

- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | INITIAL/RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES |
| **Required Medical Information** | INITIAL: HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 1) 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 2) 7.5% UNINTENTIONAL WEIGHT LOSS OVER 6 MONTHS, 3) 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, 4) BODY CELL MASS (BCM) LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 5) BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR 6) BMI LESS THAN 18.5 KG PER METER SQUARED. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HIV/WASTING: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 3 MONTHS. |
| **Other Criteria** | HIV/WASTING: INITIAL: 1) CURRENTLY ON HIV ANTIRETROVIRAL THERAPY, AND 2) INADEQUATE RESPONSE TO ONE PREVIOUS THERAPY (E.G., MEGACE, APPETITE STIMULANTS, ANABOLIC STEROIDS). RENEWAL: 1) CURRENTLY ON HIV ANTIRETROVIRAL THERAPY, AND 2) CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SONIDEGIB

## Products Affected

- ODOMZO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | LOCALLY ADVANCED BASAL CELL CARCINOMA (BCC): BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SORAFENIB

## Products Affected

- *sorafenib*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SOTORASIB

## Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# STIRIPENTOL

## Products Affected

- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | DRAVET SYNDROME: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | INITIAL/RENEWAL: 12 MONTHS. |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# SUNITINIB

## Products Affected

- *sunitinib malate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO IMATINIB (GLEEVEC). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TADALAFIL

## Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH). |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | BPH: 1) TRIAL OF ONE ALPHA BLOCKER (E.G., DOXAZOSIN, TERAZOSIN, TAMSULOSIN, ALFUZOSIN), AND 2) TRIAL OF ONE 5-ALPHA-REDUCTASE INHIBITOR (E.G., FINASTERIDE, DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TAFAMIDIS

## Products Affected

- VYNDAMAX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TALAZOPARIB

## Products Affected

- TALZENNA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | NONE |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TASIMELTEON

## Products Affected

- HETLIOZ LQ
- *tasimelteon*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | LIFETIME |
| **Other Criteria** | NON-24 HOUR SLEEP-WAKE DISORDER: PATIENT IS LIGHT-INSENSITIVE OR HAS TOTAL BLINDNESS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TAZEMETOSTAT

## Products Affected

- TAZVERIK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TEDUGLUTIDE

## Products Affected

- GATTEX 30-VIAL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | SHORT BOWEL SYNDROME (SBS): INITIAL/RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS |
| **Other Criteria** | SBS: INITIAL: PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK. RENEWAL: ACHIEVED OR MAINTAINED A DECREASED NEED FOR PARENTERAL SUPPORT COMPARED TO BASELINE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TELOTRISTAT

## Products Affected

- XERMELO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CARCINOID SYNDROME DIARRHEA: PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR GASTROENTEROLOGIST |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TEPOTINIB

## Products Affected

- TEPMETKO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TERIFLUNOMIDE

## Products Affected

- *teriflunomide*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TESAMORELIN

## Products Affected

- EGRIFTA SV

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TETRABENAZINE

## Products Affected

- *tetrabenazine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | HUNTINGTONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TEZACAFTOR/IVACAFTOR

## Products Affected

- SYMDEKO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CYSTIC FIBROSIS (CF): INITIAL: CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | CF: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: LIFETIME |
| **Other Criteria** | CF: RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# THALIDOMIDE

## Products Affected

- THALOMID

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TIVOZANIB

## Products Affected

- FOTIVDA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TOCILIZUMAB IV

## Products Affected

- TYENNE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. |
| **Coverage Duration** | INITIAL: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: RA, PJIA, SJIA, GCA: 12 MONTHS. |
| **Other Criteria** | INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
|---|---|
| **Part B Prerequisite** | No |

# TOCILIZUMAB SQ

## Products Affected

- TYENNE
- TYENNE AUTOINJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). SSC-ILD: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS). RENEWAL: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. SSC-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TOFACITINIB

## Products Affected

- XELJANZ
- XELJANZ XR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA, PCJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: RA, PSA, AS, PCJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |

| PA Criteria | Criteria Details |
|---|---|
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TOPICAL TRETINOIN

## Products Affected

- *tretinoin topical cream 0.025 %, 0.05 %, 0.1 %*
- *tretinoin topical gel*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | COSMETIC INDICATIONS SUCH AS WRINKLES, PHOTOAGING, MELASMA. |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TRAMETINIB

## Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TRAZODONE

## Products Affected

- RALDESY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | MAJOR DEPRESSIVE DISORDER (MDD): CONTRAINDICATION TO OR UNABLE TO SWALLOW TRAZODONE TABLETS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TRIENTINE

## Products Affected

- *trientine oral capsule 250 mg, 500 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | WILSONS DISEASE: INITIAL: KNOWN FAMILY HISTORY OF WILSONS DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSONS DISEASE. CONFIRMATION OF ONE OF THE FOLLOWING: 1) PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL, 2) LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS, OR 3) CONFIRMATION BY GENETIC TESTING FOR ATP7B MUTATIONS. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | WILSONS DISEASE: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST. |
| **Coverage Duration** | INITIAL: 12 MONTHS, RENEWAL: LIFETIME. |
| **Other Criteria** | WILSONS DISEASE: INITIAL: TRIAL OF OR CONTRAINDICATION TO FORMULARY VERSION OF PENICILLAMINE (DEPEN). RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TRIFLURIDINE/TIPIRACIL

## Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TRIPTORELIN-TRELSTAR

## Products Affected

- TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS. |
| **Other Criteria** | THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TRUQAP

## Products Affected

- TRUQAP

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer with 1 or more PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test and, A.) patient has had disease progression following 1 or more endocrine-based regimen(s) in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy, and B.) will be used in combination with fulvestrant injection. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# TUCATINIB

## Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# UBROGEPANT

## Products Affected

- UBRELVY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | ACUTE MIGRAINE TREATMENT: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE TRIPTAN (E.G., SUMATRIPTAN, RIZATRIPTAN). RENEWAL: 1) IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE, OR 2) THERAPY WORKS CONSISTENTLY IN MAJORITY OF MIGRAINE ATTACKS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# UPADACITINIB

## Products Affected

- RINVOQ
- RINVOQ LQ

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: RA, AS, NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. UC: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. ATOPIC DERMATITIS: 1) ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS, 2) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 3) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING: TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR, OR TOPICAL JAK INHIBITOR, AND 4) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR THE TREATMENT OF ATOPIC DERMATITIS. UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). RENEWAL: RA, PSA, AS, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION. ATOPIC DERMATITIS: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR THE TREATMENT OF ATOPIC DERMATITIS. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# USTEKINUMAB

## Products Affected

- STELARA SUBCUTANEOUS
- YESINTEK SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. |
| **Coverage Duration** | INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. |
| **Other Criteria** | INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: PSA, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

| PA Criteria | Criteria Details |
| --- | --- |
| **Part B Prerequisite** | No |

# VALBENAZINE

## Products Affected

- INGREZZA
- INGREZZA INITIATION PK(TARDIV)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | TARDIVE DYSKINESIA (TD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | TD: 1) PRIOR HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA, AND 2) TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: AUSTEDO. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VANDETANIB

## Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | CURRENTLY STABLE ON CAPRELSA REQUIRES NO EXTRA CRITERIA. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VANFLYTA

## Products Affected

- VANFLYTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | Patient must have all of the following A.) Newly diagnosed acute myeloid leukemia with FLT3-ITD mutation, B.) Used in combination with standard cytarabine and anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy, and C.) Must be enrolled in the VANFLYTA REMS program |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VEMURAFENIB

## Products Affected

- ZELBORAF

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | MELANOMA: ZELBORAF WILL BE USED ALONE OR IN COMBINATION WITH COTELLIC |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VENETOCLAX

## Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VERQUVO

## Products Affected

- VERQUVO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Any of the following A.) Concomitant use of other soluble guanylate cyclase (sGC) stimulators, or B.) Pregnancy |
| **Required Medical Information** | Diagnosis of chronic heart failure (HF), NYHA Class II to IV and all of the following 1.) Left ventricular ejection fraction less than 45%, 2.) Previous hospitalization for HF within 6 months or outpatient IV diuretic treatment for HF within 3 months |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a cardiologist |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VIGABATRIN

## Products Affected

- *vigabatrin*
- *vigadrone*
- VIGAFYDE
- *vigpoder*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | REFRACTORY COMPLEX PARTIAL SEIZURES (CPS), INFANTILE SPASMS: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST. |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | CPS: 1) TRIAL OF OR CONTRAINDICATION TO TWO ANTIEPILEPTIC AGENTS AND 2) BENEFITS OUTWEIGH THE POTENTIAL FOR VISION LOSS. INFANTILE SPASMS: BENEFITS OUTWEIGH THE POTENTIAL FOR VISION LOSS. |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VIMSELTINIB

## Products Affected

- ROMVIMZA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VISMODEGIB

## Products Affected

- ERIVEDGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VORASIDENIB

## Products Affected

- VORANIGO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# VORICONAZOLE SUSPENSION

## Products Affected

- *voriconazole oral suspension for reconstitution*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | CANDIDA INFECTIONS: 3 MOS. ALL OTHER INDICATIONS: 6 MOS. |
| **Other Criteria** | CANDIDA INFECTIONS: TRIAL OF OR CONTRAINDICATION TO FLUCONAZOLE. ALL INDICATIONS: INABILITY TO SWALLOW TABLETS OR AN INDICATION FOR ESOPHAGEAL CANDIDIASIS. CONTINUATION OF THERAPY AFTER HOSPITAL DISCHARGE REQUIRES NO EXTRA CRITERIA. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ZANUBRUTINIB

## Products Affected

- BRUKINSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 MONTHS |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# ZURZUVAE

## Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of postpartum depression |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 14 days |
| **Other Criteria** | None |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

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