ACITRETIN

MEDICATION(S)
ACITRETIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. For psoriasis: inadequate response, intolerance, or contraindication to methotrexate or cyclosporine. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ACTIMMUNE

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ACUTE SEIZURE AGENTS

MEDICATION(S)
NAYZILAM, VALTOCO 10 MG DOSE, VALTOCO 15 MG DOSE, VALTOCO 20 MG DOSE, VALTOCO 5 MG DOSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Acute narrow-angle glaucoma.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Applies to new starts only.

AGE RESTRICTION
12 years of age and older for Nayzilam (midazolam). 6 years of age and older for Valtoco (diazepam).

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ADALIMUMAB-AACF

MEDICATION(S)

ADALIMUMAB-AACF (2 PEN), ADALIMUMAB-AACF (2 SYRINGE), ADALIMUMAB-AACF(CD/UC/HS STRT), ADALIMUMAB-AACF(PS/UV STARTER), IDACIO, IDACIO FOR CROHNS DISEASE/UC, IDACIO FOR PLAQUE PSORIASIS

PENDING CMS APPROVAL

ADEMPAS

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Female patients who are pregnant or planning on becoming pregnant. Concurrent use with nitrates or nitric oxide donors in any form. Concurrent use with phosphodiesterase inhibitors. Pulmonary hypertension associated with idiopathic interstitial pneumonias (PH-IIP).

REQUIRED MEDICAL INFORMATION
Diagnosis of Pulmonary Arterial Hypertension WHO Group 1 with New York Heart Association (NYHA) Functional Class II-III by complete right heart catheterization (RHC) with results attached. Mean pulmonary artery pressure (mPAP) greater than 20 mmHg, pulmonary vascular resistance (PVR) greater than 3 wood units, and a mean pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. For WHO group IV: Confirmed diagnosis of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) with documentation verifying that patient has recurrent or persisting pulmonary hypertension following pulmonary thromboendarterectomy or inoperable CTEPH. For all diagnosis: Confirmation treatment plan is in place.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a cardiologist, pulmonologist, or practitioner at a Pulmonary Hypertension Association-Accredited center.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

ALOSETRON

MEDICATION(S)
ALOSETRON HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Exclude if male gender.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of severe diarrhea-predominant irritable bowel syndrome. Documentation of inadequate response, intolerance, or contraindication to one of the following: an anti-diarrheal agent (e.g. loperamide), an anti-spasmodic agent (e.g. dicyclomine), or a tricyclic antidepressant (e.g. amitriptyline, nortriptyline, desipramine, imipramine).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ALPHA1-PROTEINASE INHIBITORS

MEDICATION(S)
PROLASTIN-C

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Immunoglobulin A (IgA) deficient patients with antibodies against IgA.

REQUIRED MEDICAL INFORMATION
Diagnosis of emphysema due to severe congenital deficiency of Alpha1-PI (alpha1-antitrypsin deficiency). Documentation of testing that confirms one of the following homozygous protein phenotypes: Pi*ZZ, Pi*Z(null) or Pi*(null)(null) AND labs that show baseline (pretreatment) serum alpha1-antitrypsin concentration of less than 11 micromol/L as documented by either of the following: less than 57 mg/dL as determined by nephelometry OR less than 80mg/dL as determined by radial immunodiffusion. Confirmation that the member does not have selective IgA deficiencies with known antibodies against IgA (anti-IgA antibodies).

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a pulmonologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ALVAIZ

MEDICATION(S)
ALVAIZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis: 1) chronic immune thrombocytopenia (ITP), 2) thrombocytopenia in patients with chronic hepatitis C, or 3) severe aplastic anemia. For ITP: Documentation that baseline platelet count is less than 30,000/mcL. Documentation of inadequate response, intolerance, or contraindication to glucocorticoids (prednisone, dexamethasone or methylprednisolone), immunoglobulins, or splenectomy. For chronic hepatitis C: Documentation of patient's degree of thrombocytopenia (e.g. less than 75,000/mcL) that prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy. For severe aplastic anemia: Documentation that baseline platelet count is less than 30,000/mcL. Documentation of inadequate response, intolerance, or contraindication to immunosuppressive therapy.

AGE RESTRICTION
For ITP: 6 years or older. For thrombocytopenia in patients with chronic hepatitis C and severe aplastic anemia: 18 years or older.

PRESCRIBER RESTRICTION
For ITP and severe aplastic anemia: hematologist. For thrombocytopenia in patients with chronic hepatitis C: hematologist, hepatologist, or infectious disease specialist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation that patient had a positive clinical response and remains at risk for

bleeding complications.

PART B PREREQUISITE

N/A

ANTIANDROGEN ORAL ONCOLOGY AGENTS

MEDICATION(S)
ABIRATERONE ACETATE, ERLEADA, NUBEQA, XTANDI

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. For Nubeqa: Documentation of inadequate response, intolerance, or contraindication to one of the following: abiraterone, Erleada, or Xtandi. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

APOMORPHINE INJECTION

MEDICATION(S)
APOMORPHINE HCL 30 MG/3ML SOLN CART

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with 5-HT3 receptor antagonists, including antiemetics (e.g., ondansetron, granisetron, palonosetron, alosetron).

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Parkinson’s disease (PD) with intermittent off episodes. Documentation showing an inadequate response, intolerance, or contraindication to at least two conventional oral therapies (e.g., carbidopa-levodopa, pramipexole, ropinirole, bromocriptine, amantadine, selegiline, rasagiline, trihexyphenidyl, benztropine, entacapone, tolcapone).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ARCALYST

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), Familial Cold Autoinflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS), Deficiency of Interleukin-1 Receptor Antagonist (DIRA), Recurrent Pericarditis (RP). For DIRA: Patient weight of at least 10 kg. Documentation showing need for maintenance of remission. For RP: Documentation showing a trial of, intolerance to, or contraindication to at least one of the following: nonsteroidal anti-inflammatory drugs, colchicine, or corticosteroids.

AGE RESTRICTION
For CAPS, FCAS, MWS, RP: 12 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ARIKAYCE

MEDICATION(S)
ARIKAYCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of Mycobacterium avium complex (MAC) lung disease. Confirmation that the medication is being used as part of a combination antibacterial drug regimen. Confirmation that the patient did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a pulmonologist or an infectious disease specialist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

AUSTEDO

MEDICATION(S)
AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRATION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Congenital long QT syndrome. History of cardiac arrhythmias. Hepatic impairment. Concurrent use of MAO inhibitors. Concurrent use of reserpine, tetrabenazine or valbenazine. For a diagnosis of Chorea associated with Huntington’s Disease: suicidal patients and patients with untreated or inadequately treated depression.

REQUIRED MEDICAL INFORMATION
Initial: For Tardive Dyskinesia: Documented diagnosis of Tardive Dyskinesia including copy of Abnormal Involuntary Movement Scale (AIMS) assessment. Documentation that other movement disorders (such as Parkinson’s disease, Chorea associated with Huntington’s Disease) have been excluded with documentation attached. Documentation of current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine, etc). For Chorea associated with Huntington’s Disease: Documentation showing that other movement disorders (such Tardive Dyskinesia, or Parkinson’s disease) have been excluded with documentation attached. Documentation showing confirmation of a diagnosis of Chorea associated with Huntington’s Disease with documentation attached.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist or psychiatrist.

COVERAGE DURATION
12 months.

OTHER CRITERIA

For reauthorization: For Tardive Dyskinesia: Improvement in symptoms of Tardive Dyskinesia with an updated AIMS assessment. Documentation must be attached. For Chorea associated with Huntington's Disease: Improvement in symptoms of Chorea with medical records attached.

PART B PREREQUISITE

N/A

BENLYSTA

MEDICATION(S)
BENLYSTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis of either systemic lupus erythematosus (SLE) or active lupus nephritis (LN). For SLE: Documentation of inadequate response, intolerance, or contraindication to at least 1 standard therapy (e.g. hydroxychloroquine, mycophenolate, azathioprine). For LN: Documentation of inadequate response, intolerance, or contraindication to at least 1 standard therapy (e.g. mycophenolate, IV or oral cyclophosphamide, azathioprine, oral glucocorticoid).

AGE RESTRICTION
5 years or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a rheumatologist or nephrologist

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Documentation of a positive clinical response.

PART B PREREQUISITE
N/A

BERINERT

MEDICATION(S)
BERINERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Subject to Part B vs Part D review. Documentation of a diagnosis of hereditary angioedema (HAE). Confirmation that Berinert is being used for the treatment of acute HAE attacks. Not to be used in combination with other approved treatments for acute HAE attacks.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or prescriber who specializes in the management of HAE.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation of reduction in severity or duration of attacks.

PART B PREREQUISITE
N/A

BESREMI

MEDICATION(S)
BESREMI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Documentation of inadequate response, intolerance, or contraindication to hydroxyurea.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist or oncologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BEXAROTENE GEL

MEDICATION(S)
BEXAROTENE 1 % GEL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatologist, hematologist, oncologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BOTULINUM TOXINS

MEDICATION(S)
BOTOX, XEOMIN

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Sialorrhea associated with disorders of the nervous system or neurologic dysfunction. Hemifacial spasm. Laryngeal dystonia. Spasticity associated with cerebral palsy.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR ALL REQUESTS: Documentation of diagnosis, proposed injection site(s) and the dose that will be injected into each site. IN ADDITION: FOR INITIAL REQUESTS: (1)For OAB with symptoms of urge urinary incontinence, urgency, and frequency: documentation of inadequate response or intolerance to an anticholinergic medication, dose no more than 100 units/treatment. (2)For urinary incontinence due to detrusor overactivity associated with a neurologic condition: inadequate response or intolerance to an anticholinergic medication, dose no more than 200 units/treatment. (3)For prophylaxis of headaches in adult patients with chronic migraine (at least 15 days per month with headache lasting 4 hours a day or longer): documentation of inadequate response or intolerance to at least 2 different classes of prophylactic medications (i.e., beta blockers [such as propranolol, metoprolol], amitriptyline, topiramate, valproic acid or its derivatives, verapamil), dose no more than 155 units/treatment. (4)For severe primary axillary hyperhidrosis: documentation of dose no more than 100 units/treatment. (5)For upper or lower limb spasticity in muscle groups FDA-approved for treatment: documentation of dose no more than 400 units/treatment. (6)For blepharospasm associated with dystonia: dose no more than 200 units/treatment. (7)For strabismus associated with dystonia: dose no more than 25 units per muscle per injection. (8)For sialorrhea associated with disorders of the nervous system or neurologic dysfunction, documentation of diagnosis and inadequate response or intolerance to at least 1 anticholinergic medication (e.g., glycopyrrolate). (9)For cervical dystonia: dose no more than 300 units/treatment. FOR RENEWAL REQUESTS: Dose consistent with total units for diagnosis (per initial request criteria). Documentation supporting the need for repeat treatment(s) occurring no sooner than every 3 months.

AGE RESTRICTION

18 years of age or greater for diagnoses of OAB, urinary incontinence, prophylaxis of headaches in patients with chronic migraine, severe primary axillary hyperhidrosis. 16 years of age or greater for diagnosis of cervical dystonia. 12 years of age or greater for diagnoses of blepharospasm or strabismus associated with dystonia.

PRESCRIBER RESTRICTION

Urologist/neurologist: OAB, urinary incontinence. Neurologist: Migraine headaches. Neurologist/Physiatrist: Upper limb spasticity, cervical dystonia. Ophthalmologist: Blepharospasm, strabismus. Dermatologist/Neurologist/Physiatrist: Severe primary axillary hyperhidrosis.

COVERAGE DURATION

12 months.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

BRAND MAJOR DEPRESSIVE DISORDER AGENTS

MEDICATION(S)
AUVELITY, EMSAM, FETZIMA, FETZIMA TITRATION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Major Depressive Disorder. Documentation of an inadequate response, intolerance, or contraindication to two of the following: selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, atypical agents, serotonin modulators, tricyclics. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BRIVIACT

MEDICATION(S)
BRIVIACT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of partial-onset seizures. Documentation of an inadequate response, intolerance, or contraindication to levetiracetam and at least one of the following: carbamazepine, divalproex, gabapentin, lacosamide, lamotrigine, oxcarbazepine, topiramate. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

BRONCHITOL

MEDICATION(S)
BRONCHITOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Confirmation that patient has passed a Bronchitol Tolerance Test. Confirmation that Bronchitol will be used in conjunction with standard therapies (e.g., bronchodilators, inhaled antibiotics) to improve pulmonary function. For reauthorization, confirmation of improvement in condition.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CARGLUMIC ACID

MEDICATION(S)
CARGLUMIC ACID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Documentation showing use as adjunctive therapy to standard of care for treatment of acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency. Documentation showing use for maintenance therapy for the treatment of chronic hyperammonemia due to NAGS deficiency. Documentation showing use as adjunctive therapy to standard of care for the treatment of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with prescriber experienced in metabolic disorders.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CAYSTON

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of cystic fibrosis (CF) and lung infection with airway cultures positive for pseudomonas aeruginosa.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a pulmonologist, a physician who specializes in the treatment of cystic fibrosis, or an infectious disease specialist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CERDELGA

MEDICATION(S)
CERDELGA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of type 1 Gaucher Disease (GD1) and documentation that patient is a CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) as detected by an FDA-approved genetic test.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CFTR MODULATORS

MEDICATION(S)
KALYDECO, ORKAMBI, TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes that show that the diagnosis of cystic fibrosis is confirmed. Chart notes that show that appropriate genetic testing has been conducted. Chart notes showing that lab work (baseline liver function tests, including alanine aminotransferase, aspartate aminotransferase and bilirubin) has been assessed prior to initiation of treatment. For Kalydeco: Confirmation of one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data. For Orkambi: Confirmation of homozygous for the F508del mutation in the CFTR gene. For Trikafta: Confirmation of at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on in vitro data.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with pulmonologist, endocrinologist, or pediatrician.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CGRP ANTAGONISTS

MEDICATION(S)
AIMOVIG, EMGALITY, EMGALITY (300 MG DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Notes showing diagnosis and patient having at least 4 migraine days per month. For migraine: Confirmation of intolerance or inadequate response to a trial with at least one preventive medication from two of the following classes: beta blockers, antidepressants, anticonvulsants. For episodic cluster headaches (Emgality only): Confirmation of a history of inadequate response, intolerance, or contraindication to at least one other preventative medication recommended by current consensus guidelines for episodic cluster headache (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CINRYZE

MEDICATION(S)
CINRYZE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Subject to Part B vs Part D review. Documentation of a diagnosis of hereditary angioedema (HAE). Confirmation that Cinryze is being used for prophylaxis against HAE attacks. Not to be used in combination with other approved treatments for prophylaxis against HAE attacks.

AGE RESTRICTION
6 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or prescriber who specializes in the management of HAE.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation of reduction in severity or duration of attacks.

PART B PREREQUISITE
N/A

CLOBAZAM

MEDICATION(S)
CLOBAZAM

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS), refractory seizures/epilepsy, or seizures associated with Dravet syndrome (DS). For LGS: documentation of an inadequate response, intolerance, contraindication, or is concomitantly receiving one of the following: valproate, lamotrigine, rufinamide, cannabidiol (Epidiolex), felbamate. For refractory seizures/epilepsy: documentation of an inadequate response, intolerance, contraindication, or is concomitantly receiving two antiepileptics such as: felbamate, lamotrigine, levetiracetam, topiramate, valproate, zonisamide. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

CORLANOR

MEDICATION(S)
CORLANOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
One of the following: 1) Documentation of diagnosis of chronic heart failure (CHF). Stable symptomatic NYHA class II to IV heart failure with reduced left ventricular ejection fraction (EF). Documentation of EF less than or equal to 35 percent. Patient is in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute. Patient has intolerance, contraindication, or is on maximally tolerated doses of beta-blockers. Or, 2) Documentation of diagnosis of stable symptomatic heart failure due to Dilated Cardiomyopathy (CHF-DC). Patient is in sinus rhythm with an elevated heart rate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: patient has a positive clinical response.

PART B PREREQUISITE
N/A

CYSTARAN

MEDICATION(S)
CYSTARAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of cystinosis. Documentation showing patient has corneal cystine crystal accumulation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DEFERASIROX

MEDICATION(S)
DEFERASIROX, DEFERASIROX GRANULES

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Estimated glomerular filtration rate (GFR) less than 40 mL/min or serum creatinine more than 2 times the age-appropriate upper normal limit, platelet counts less than 50,000/mL, high-risk myelodysplastic syndromes (MDS), and advanced malignancies.

REQUIRED MEDICAL INFORMATION
For the treatment of chronic iron overload caused by blood transfusions: Documentation of serum ferritin levels consistently greater than 300 mcg/L. For chronic iron overload in nontransfusion-dependent thalassemia syndromes: Documentation of liver iron concentration (LIC) of at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) AND documentation of serum ferritin level greater than 300 mcg/L on 2 consecutive measurements 1 month apart.

AGE RESTRICTION
Treatment of chronic iron overload caused by blood transfusions: 2 years of age and older. Chronic iron overload in nontransfusion-dependent thalassemia syndromes: 10 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist, oncologist, or hepatologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DEFERIPRONE

MEDICATION(S)
DEFERIPRONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of transfusional iron overload due to thalassemia syndromes, sickle cell disease or other anemias. Documentation of Absolute Neutrophil Count (ANC) greater than or equal to 1.5 x 1000000000 (10 to the ninth power) per liter.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with hematologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DIACOMIT

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Dravet syndrome (DS). Documentation of an inadequate response, intolerance, or contraindication to at least two of the following: clobazam, valproic acid derivatives, topiramate, levetiracetam, cannabidiol (pharmaceutical). Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DIHYDROERGOTAMINE NASAL SPRAY

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE 4 MG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Uncontrolled hypertension. Use as management of hemiplegic basilar migraine. Ischemic heart disease (e.g. angina pectoris, history of myocardial infarction, or documented silent ischemia) or coronary artery vasospasm including Prinzmetal's variant angina. Concomitant use or use within 24 hours of ergotamine containing or ergot type medications or methysergide. Coadministration with strong CYP3A4 inhibitors and peripheral and central vasoconstrictors. Peripheral arterial disease, sepsis, following vascular surgery, and severely impaired hepatic or renal function. Hypersensitivity to ergot alkaloids.

REQUIRED MEDICAL INFORMATION
Documentation to confirm diagnosis of acute treatment of migraine headaches with or without aura. Confirmation that drug will not be used for prophylactic migraine therapy. Documentation of an inadequate response, intolerance, or contraindication to two generic triptans (such as sumatriptan, zolmitriptan, rizatriptan) OR an inadequate response, intolerance, or contraindication to one generic triptan AND a gepant.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

DOPTELET

MEDICATION(S)
DOPTELET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis: 1) thrombocytopenia with chronic liver disease, 2) chronic immune thrombocytopenia (ITP). For thrombocytopenia with chronic liver disease: Documentation that baseline platelet count is less than 50,000/mcL. Documentation that the patient is scheduled to undergo a procedure. For ITP: Documentation that baseline platelet count is less than 30,000/mcL. Documentation of inadequate response, intolerance, or contraindication to one of the following: glucocorticoids (prednisone, dexamethasone, or methylprednisolone), immunoglobulins, or splenectomy.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
For ITP: hematologist. For thrombocytopenia in patients with chronic liver disease: hematologist, hepatologist, or infectious disease specialist.

COVERAGE DURATION
Chronic liver disease: 1 month. ITP: 12 months.

OTHER CRITERIA
For reauthorization: Confirmation that patient had a positive clinical response and remains at risk for bleeding complications.

PART B PREREQUISITE

N/A

DRIZALMA SPRINKLE

MEDICATION(S)
DRIZALMA SPRINKLE 20 MG CAP DR, DRIZALMA SPRINKLE 30 MG CAP DR, DRIZALMA SPRINKLE 60 MG CAP DR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation showing that administration via nasogastric tube is required or documentation showing inability to or difficulty with swallowing solid dosage forms. Documentation of diagnosis. For major depressive disorder (MDD): documentation of inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g., fluoxetine solution, citalopram solution, escitalopram solution, sertraline oral concentrate, paroxetine suspension). For generalized anxiety disorder (GAD): documentation of inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g., escitalopram solution, paroxetine suspension). For diabetic peripheral neuropathic pain (DPNP): documentation of inadequate response, intolerance, or contraindication to gabapentin solution. For fibromyalgia (FM): documentation of inadequate response, intolerance, or contraindication to gabapentin solution. Applies to new starts only.

AGE RESTRICTION
For MDD, DPNP, FM, chronic musculoskeletal pain: 18 years of age and older. For GAD: 7 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

DRONABINOL

MEDICATION(S)
DRONABINOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
One of the following: Documented diagnosis of anorexia associated with weight loss in patients with AIDS OR documented diagnosis of chemotherapy-induced nausea and vomiting in patients with inadequate response to conventional antiemetic treatments [such as 5-HT3 (serotonin) receptor antagonists, NK1 (neurokinin-1) receptor antagonists, glucocorticoids]. Medication may be covered under Medicare Part B or D depending upon the circumstances. Information to be submitted describing the use and setting of the drug to make the determination.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

DROXIDOPA

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of neurogenic orthostatic hypotension (nOH) caused by one of the following: (1) primary autonomic failure (e.g. Parkinson's disease, multiple system atrophy, and pure autonomic failure), (2) dopamine beta-hydroxylase deficiency, or (3) non-diabetic autonomic neuropathy. Documentation of an inadequate response, intolerance, or contraindication to fludrocortisone or midodrine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a cardiologist or a neurologist.

COVERAGE DURATION
3 months.

OTHER CRITERIA
For reauthorization: the patient has had a positive clinical response with improvement in symptoms.

PART B PREREQUISITE
N/A

DUPIXENT

MEDICATION(S)
DUPIXENT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Active helminth infection.

REQUIRED MEDICAL INFORMATION
For moderate-to-severe atopic dermatitis when disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable: For patients under age 2, documentation showing a trial of, intolerance to, or contraindication to at least one topical steroid. For patients over age 2, documentation showing a trial of, intolerance to, or contraindication to at least one topical corticosteroid and at least one topical calcineurin inhibitor. For add on maintenance therapy for the treatment of moderate to severe asthma with eosinophilic type: Documentation showing a diagnosis of eosinophilic asthma including eosinophil count greater than or equal to 150 cells per microliter (lab results required). Documentation showing a trial of, intolerance to, or contraindication to at least one combination therapy (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline). For add on maintenance therapy for the treatment of oral corticosteroid dependent asthma: Documentation showing oral corticosteroid dependent asthma. Documentation showing trial of, intolerance to, or contraindication to at least one combination therapy (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline). For patients with chronic rhinosinusitis with nasal polyposis (CRSwNP): Documentation of a diagnosis of CRSwNP. Documentation showing a trial of, intolerance to, or contraindication to at least one intranasal corticosteroid and at least one systemic corticosteroid. Documentation showing the patient will be treated with Dupixent in combination with intranasal corticosteroids. For patients with eosinophilic esophagitis: Documentation of a diagnosis of eosinophilic esophagitis. Documentation showing a trial of, intolerance to, or contraindication to at least one proton pump inhibitor. Documentation showing a trial of, intolerance to, or contraindication to inhaled fluticasone propionate. Continued in OTHER CRITERIA.

AGE RESTRICTION
6 months of age or older for atopic dermatitis. 6 years of age and older for eosinophilic phenotype or

oral corticosteroid dependent asthma.12 years of age and older for CRSwNP. 1 year of age and older for EOE. 18 years of age and older for COPD and prurigo nodularis.

PRESCRIBER RESTRICTION
Pulmonologist, allergist, immunologist, dermatologist, otolaryngologist, gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For prurigo nodularis: Documentation of diagnosis. Documentation showing a trial, intolerance, or contraindication to one high potency topical steroid. For chronic obstructive pulmonary disease (COPD), eosinophilic phenotype: Documentation showing a diagnosis of COPD with an eosinophilic phenotype including eosinophil count greater than 300 cells per microliter (lab results required). Notes showing COPD is inadequately controlled. Documentation showing a trial of intolerance to, or contraindication to at least one inhaled combination therapy (including LAMA/LABA or LAMA/LABA/ICS combination therapies). Documentation showing a trial of intolerance to, or contraindication to chronic azithromycin therapy or roflumilast. For reauthorization: Confirmation of positive clinical response

PART B PREREQUISITE
N/A

ENBREL

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of the results of PPD test and treatment plan to address latent or active infection. Confirmation of diagnosis of rheumatoid arthritis (RA), psoriatic arthritis (PsA), juvenile psoriatic arthritis (jPsA), plaque psoriasis (PsO), polyarticular juvenile idiopathic arthritis (pJIA), or ankylosing spondylitis (AS). For RA or PsA or jPsA: Documentation of inadequate response intolerance, or contraindication to at least one conventional DMARD. For PsO (moderate to severe disease): Documentation that patient is a candidate for systemic therapy or phototherapy and documentation of inadequate response, intolerance, or contraindication to methotrexate OR UVB therapy OR Acitretin (requires prior authorization). For PsO (limited disease): Documentation of inadequate response, intolerance, or contraindication to one topical steroid (high or very high potency) AND calcipotriene. For moderately to severely active polyarticular pJIA: Documentation of inadequate response, intolerance, or contraindication to one conventional DMARD. For AS: Documentation of inadequate response, intolerance, or contraindication to at least two non-steroidal anti-inflammatory drugs (NSAIDs).

AGE RESTRICTION
For RA, AS: 18 years of age and older. For PsO: 4 years of age and older. For pJIA, PsA: 2 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a rheumatologist or dermatologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA

For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

ENDOTHELIN RECEPTOR ANTAGONISTS

MEDICATION(S)
AMBRISENTAN, BOSENTAN, OPSUMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Pregnancy. For ambrisentan, a diagnosis of idiopathic pulmonary fibrosis. For bosentan, use with glyburide and/or cyclosporine A.

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis of pulmonary arterial hypertension (PAH) WHO Group 1. Diagnosis confirmed by a complete right heart catheterization (RHC). PAH defined as a resting mean pulmonary artery pressure (mPAP) of greater than 20 mmHG, pulmonary capillary wedge pressure (PCWP), left atrial pressure, or left ventricular end-diastolic pressure of less than or equal to 15 mmHg, and pulmonary vascular resistance (PVR) of greater than 3 Wood units. RHC results must be provided. Confirmation that hemoglobin, liver function tests, and bilirubin are being monitored. If female of childbearing age, documentation showing reliable contraception will be used during and after treatment and confirmation of negative pregnancy test prior to starting medication.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a cardiologist, pulmonologist, or practitioner at a Pulmonary Hypertension Association-Accredited center.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: documentation showing treatment response and monitoring.

PART B PREREQUISITE

N/A

EPIDIOLEX

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Hypersensitivity to cannabidiol or any of the ingredients in the product.

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Dravet syndrome (DS), Lennox-Gastaut syndrome (LGS) or Tuberous Sclerosis Complex (TSC). Documentation of baseline serum transaminases (ALT and AST) and total bilirubin levels prior to initiation of treatment and confirmation that these labs will be monitored periodically during treatment. Documentation showing that patient has failed to become seizure-free with at least 2 antiepileptic drugs (specify drugs tried). Confirmation that Epidiolex is adjunctive therapy with documentation of antiepileptic drug(s) with which Epidiolex will be used. Applies to new starts only.

AGE RESTRICTION
1 year of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
Request is within FDA approved labeled dose not exceeding 20 mg/kg/day for treatment of seizures associated with Lennox-Gastaut syndrome and Dravet syndrome or dose not exceeding 25 mg/kg/day for treatment of seizures associated with Tuberous Sclerosis Complex.

PART B PREREQUISITE
N/A

EPRONTIA

MEDICATION(S)
EPRONTIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Confirmation of difficulty swallowing solid dosage forms. Documentation of an inadequate response, intolerance, or contraindication to generic formulary topiramate. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FASENRA

MEDICATION(S)
FASENRA, FASENRA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For add-on maintenance treatment of severe asthma: Documentation showing confirmation of the following: diagnosis of severe asthma with an eosinophil count greater than or equal to 150 cells per microliter (lab results required) AND inadequate response, intolerance or contraindication to treatment with an inhaled ICS/LABA (inhaled corticosteroid/long-acting beta-agonist) with or without other controllers, including systemic steroids, antileukotrienes. For eosinophilic granulomatosis with polyangiitis (EGPA): Documentation showing history of asthma. Documentation of absolute blood eosinophil count greater than or equal to 1000 cells per microliter or blood eosinophil level greater than 10% of the total leukocyte count (lab results required). Documentation showing inadequate response, intolerance, or contraindication to systemic glucocorticoids. For severe EGPA including organ involvement or life-threatening disease: documentation of inadequate response, intolerance, or contraindication to rituximab or cyclophosphamide.

AGE RESTRICTION
Asthma: 6 years of age and older. EGPA: 18 years of age and older.

PRESCRIBER RESTRICTION
Asthma: Pulmonologist, allergist, immunologist. EGPA: Pulmonologist, allergist, immunologist, rheumatologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA

For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

FILGRASTIM AGENTS

MEDICATION(S)
ZARXIO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation or chart notes supporting medication is being used for a medically accepted indication not otherwise excluded from Part D. For all diagnoses, chart notes that show that lab work (complete blood count with differential including ANC) is being monitored prior to initiation of medication and during therapy based on recommendation for that specific diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

FINTEPLA

MEDICATION(S)
FINTEPLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Hypersensitivity to fenfluramine or any of the components of Fintepla. Concomitant use of, or within 14 days of administration of monoamine oxidase inhibitors.

REQUIRED MEDICAL INFORMATION
Confirmation that the patient will have required echocardiogram monitoring. Documented diagnosis of Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS). For Dravet Syndrome (DS): Documentation showing an inadequate response or intolerance to at least two of the following: clobazam, valproic acid derivatives, topiramate, levetiracetam, cannabidiol (pharmaceutical), or stiripentol (include dates, duration, and outcome of drugs tried). For Lennox-Gastaut syndrome: Documentation showing inadequate response or intolerance to at least two of the following: lamotrigine, rufinamide, topiramate, cannabidiol (pharmaceutical), clobazam, felbamate (include dates, duration, and outcome of drugs tried). Applies to new starts only.

AGE RESTRICTION
2 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

FIRDAPSE

MEDICATION(S)
FIRDAPSE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Lambert-Eaton myasthenic syndrome (LEMS). Diagnosis confirmed by neurophysiology studies or a positive anti-P/Q type voltage-gated calcium channel antibody test.

AGE RESTRICTION
6 years of age or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist or neuromuscular specialist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: confirmation of positive clinical response.

PART B PREREQUISITE
N/A

FYCOMPA

MEDICATION(S)
FYCOMPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of partial-onset seizures or generalized tonic-clonic seizures. Documentation of an inadequate response, intolerance, or contraindication to two of the following: carbamazepine, divalproex, gabapentin, lacosamide, lamotrigine, levetiracetam, oxcarbazepine, topiramate, valproate, zonisamide. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GATTEX

MEDICATION(S)
GATTEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation showing a diagnosis of short bowel syndrome and patient is dependent on parenteral support. For continuation: Documentation of reduction in parenteral support.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

GLP-1 AGONISTS

MEDICATION(S)
MOUNJARO, OZEMPIC (0.25 OR 0.5 MG/DOSE), OZEMPIC (1 MG/DOSE), OZEMPIC (2 MG/DOSE), RYBELSUS, TRULICITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Use for weight loss.

REQUIRED MEDICAL INFORMATION
Documentation showing that the member is diagnosed with type 2 diabetes mellitus. Prior authorization does not apply to patients whose claim is submitted with an ICD-10 code indicating a diagnosis of type 2 diabetes mellitus or to patients who have a history of an antidiabetic drug (excluding a history of glucagon-like peptide receptor agonists (GLP-1 RAs) and combination glucose-dependent insulinotropic polypeptide (GIP) and GLP-1 RAs).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

HAEGARDA

MEDICATION(S)
HAEGARDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of hereditary angioedema (HAE). Confirmation that Haegarda is being used for prophylaxis against HAE attacks. Not to be used in combination with other approved treatments for prophylaxis against HAE attacks.

AGE RESTRICTION
6 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or prescriber who specializes in the management of HAE.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation of reduction in severity or duration of attacks.

PART B PREREQUISITE
N/A

HARVONI

MEDICATION(S)
HARVONI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of chronic Hepatitis C (CHC). Lab results must be attached: Hepatitis C virus (HCV) genotype, quantitative HCV RNA, complete blood count (CBC), international normalized ratio (INR), hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels), transient elastography (such as FibroScan) or noninvasive serologic tests (such as FibroSure or calculate FIB-4 score), Hepatitis B surface antigen (HBsAg), and HIV antigen/antibody test. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 to 24 weeks. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

PART B PREREQUISITE
N/A

HIGH RISK MEDICATION - ANTICHOLINERGIC AGENTS

MEDICATION(S)
CYCLOBENZAPRINE HCL 10 MG TAB, CYCLOBENZAPRINE HCL 5 MG TAB, PROMETHAZINE HCL 12.5 MG TAB, PROMETHAZINE HCL 25 MG TAB, PROMETHAZINE HCL 50 MG TAB, PROMETHAZINE HCL 6.25 MG/5ML SOLUTION, SCOPOLAMINE, TRIHEXYPHENIDYL HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of patient's diagnosis and indication for use of the High Risk Medication. Confirmation that a risk-versus-benefit assessment has been completed for use of the High Risk Medication. Confirmation that the benefit outweighs the potential risk of the High Risk Medication. For allergic conditions: confirmation of an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as levocetirizine, desloratadine, azelastine nasal spray, fluticasone propionate nasal spray, or mometasone nasal spray. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient (Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline). Prior authorization applies to greater than cumulative 15 days of therapy per year.

AGE RESTRICTION
Apply if patient is 65 years of age or older to ensure safe use of a potentially high risk medication in older adults. Patients under 65 years of age are not subject to the prior authorization requirements.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA

For reauthorization: Confirmation that the benefit continues to outweigh the potential risk of the High Risk Medication.

PART B PREREQUISITE

N/A

HIGH RISK MEDICATION - BUTALBITAL COMBINATIONS

MEDICATION(S)
BAC, BUTALBITAL-APAP-CAFFEINE 50-325-40 MG TAB, BUTALBITAL-ASPIRIN-CAFFEINE 50-325-40 MG CAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of the patient's diagnosis and indication for use of the High Risk Medication. Confirmation that a risk-versus-benefit assessment has been completed for use of the High Risk Medication. Confirmation that the benefit outweighs the potential risk of the High Risk Medication.

AGE RESTRICTION
Apply if patient is 65 years of age or older to ensure safe use of a potentially high risk medication in older adults. Patients under 65 years of age are not subject to the prior authorization requirements.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation that the benefit continues to outweigh the potential risk of the High Risk Medication.

PART B PREREQUISITE
N/A

HIGH RISK MEDICATION - NON-BENZODIAZEPINE SEDATIVE HYPNOTICS

MEDICATION(S)
ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE 10 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of the patient's diagnosis and indication for use of the High Risk Medication. Confirmation that a risk-versus-benefit assessment has been completed for use of the High Risk Medication. Confirmation that the benefit outweighs the potential risk of the High Risk Medication. Confirmation of an inadequate response or inability to tolerate two safer formulary alternatives, such as trazodone, ramelteon, or doxepin (generic Silenor).

AGE RESTRICTION
Apply if patient is 65 years of age or older to ensure safe use of a potentially high risk medication in older adults. Patients under 65 years of age are not subject to the prior authorization requirements.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation that the benefit continues to outweigh the potential risk of the High Risk Medication.

PART B PREREQUISITE
N/A

HUMIRA

MEDICATION(S)

HUMIRA (2 PEN), HUMIRA (2 PEN) 40 MG/0.4ML AUT-IJ KIT (ABBVIE PRODUCT ONLY), HUMIRA (2 PEN) 80 MG/0.8ML AUT-IJ KIT (ABBVIE PRODUCT ONLY), HUMIRA (2 SYRINGE), HUMIRA 10 MG/0.1ML PREF SY KT (ABBVIE PRODUCT ONLY), HUMIRA 20 MG/0.2ML PREF SY KT (ABBVIE PRODUCT ONLY), HUMIRA 40 MG/0.4ML PREF SY KT (ABBVIE PRODUCT ONLY), HUMIRA-CD/UC/HS STARTER, HUMIRA-PED>/=40KG UC STARTER, HUMIRA-PSORIASIS/UVEIT STARTER

PENDING CMS APPROVAL

ICATIBANT

MEDICATION(S)
ICATIBANT ACETATE, SAJAZIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of hereditary angioedema (HAE). Confirmation that icatibant is being used for the treatment of acute HAE attacks. Not to be used in combination with other approved treatments for acute HAE attacks.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with allergist, immunologist, pulmonologist, or prescriber who specializes in the management of HAE.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Documentation of reduction in severity or duration of attacks.

PART B PREREQUISITE
N/A

INBRIJA

MEDICATION(S)
INBRIJA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Parkinson’s disease. Documentation that patient is experiencing OFF episodes. Confirmation that patient is currently being treated with carbidopa/levodopa.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: confirmation of positive clinical response.

PART B PREREQUISITE
N/A

INCRELEX

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Closed epiphyses.

REQUIRED MEDICAL INFORMATION
One of the following: Documentation of diagnosis of severe primary IGF1 deficiency. Diagnosis confirmed by: height standard deviation score of -3.0 or less, basal IGF-1 standard deviation score of -3.0 or less, and normal or elevated growth hormone (GH). Or, Documentation of diagnosis of growth hormone (GH) gene deletion with neutralizing antibodies to GH.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: patient has a positive clinical response.

PART B PREREQUISITE
N/A

INJECTABLE TESTOSTERONE PRODUCTS

MEDICATION(S)
TESTOSTERONE CYPIONATE 100 MG/ML SOLUTION, TESTOSTERONE CYPIONATE 200 MG/ML SOLUTION, TESTOSTERONE ENANTHATE 200 MG/ML SOLUTION

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation confirming diagnosis. For hypogonadism: Confirmed low testosterone levels in comparison to lab reference values on two separate occasions. Explanation of symptoms experienced as a result of testosterone deficiency. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Evaluation of response to testosterone therapy.

PART B PREREQUISITE
N/A

INTRAVENOUS IMMUNE GLOBULIN (IVIG)

MEDICATION(S)
BIVIGAM, FLEBOGAMMA DIF, GAMMAGARD, GAMMAGARD S/D LESS IGA, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an allergist, immunologist, hematologist, neurologist, cardiologist, or oncologist.

COVERAGE DURATION
3 months.

OTHER CRITERIA
Subject to Part B vs D review. Documentation showing confirmation that one of the following is present: (1) Autoimmune mucocutaneous blistering disease pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid, benign mucous membrane pemphigoid, epidermolysis bullosa acquisita AND one of the following: (a) inadequate response or inability to tolerate conventional therapy (e.g., steroids, immunosuppressants) OR (b) rapidly progressive disease in conjunction with conventional therapy (such as steroids, immunosuppressants), (2) Erythema multiforme major (SJS, TEN) AND SCORTEN level 3 or greater, (3) Acute idiopathic thrombocytopenia purpura (ITP) AND ONE of the following: (a) management of acute bleeding, (b) used to increase platelet count prior to surgical procedures, (c) severe thrombocytopenia (platelets less than 20,000 per

uL), OR (d) high risk for intracerebral hemorrhage, (4) Chronic ITP AND ALL of the following: (a) inadequate response or inability to tolerate corticosteroids, (b) duration of illness greater than 6 months, (c) platelets persistently less than 20,000 per uL, (5) Chronic B-cell lymphocytic leukemia with IgG less than 600 mg/dL AND recurrent, serious bacterial infections requiring antibiotic therapy, (6) Hematopoietic stem cell transplant AND IgG less than 400 mg/dL, (7) HIV and all of the following: (a) less than 14 years of age, (b) evidence of qualitative or quantitative humoral immunologic defects, AND (c) current bacterial infection despite antimicrobial prophylaxis, (8) Solid organ transplant, (9) Chronic inflammatory demyelinating polyneuritis confirmed by electrodiagnostic testing or nerve biopsy AND an inadequate response or inability to tolerate corticosteroids, (10) Dermatomyositis or polymyositis diagnosed by laboratory testing (antinuclear or myositis specific antibodies, biopsy, EMG, or MRI) AND inadequate response or inability to tolerate steroids or immunosuppressants, (11) Guillain Barre syndrome with impaired function (ie unable to stand or walk without aid), (12) Lambert Eaton myasthenic syndrome refractory to steroids, immunosuppressants, or cholinesterase inhibitors, (13) Multifocal motor neuropathy diagnosed by electrodiagnostic studies, (14) Acute exacerbations of multiple sclerosis unresponsive to steroids, (15) Myasthenia gravis refractory to at least 8 weeks of one standard therapy (steroids, immunosuppressants, cholinesterase inhibitors), (16) Myasthenic crisis, (17) Stiff person syndrome refractory to standard therapy (muscle relaxants, benzodiazepines, gabapentin), (18) Severe, active SLE unresponsive to steroids, (19) Kawasaki disease.
CONTINUATION OF THERAPY CRITERIA: Documentation of clinical improvement using objective monitoring as appropriate to the diagnosis such as, but not limited to, Rankin score and Activities of Daily Living (ADL) scores.

PART B PREREQUISITE
N/A

KERENDIA

MEDICATION(S)
KERENDIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant treatment with strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin). Adrenal insufficiency. Estimated glomerular filtration rate (GFR) less than 25 mL/min. Serum potassium is greater than 5 mEq/L.

REQUIRED MEDICAL INFORMATION
Documented diagnosis of chronic kidney disease associated with type 2 diabetes (CKD with T2D). Documentation of concomitant therapy with an angiotensin-converting enzyme (ACE) inhibitor (e.g., lisinopril, ramipril) or angiotensin II receptor blocker (ARB) (e.g., losartan, irbesartan, valsartan) at maximally tolerated dose for diabetic nephropathy unless there is an intolerance or contraindication to these therapies. Documentation of inadequate response, intolerance, or contraindication to one sodium-glucose co-transporter 2 (SGLT2) inhibitor used for chronic kidney disease (e.g., Farxiga).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

KESIMPTA

MEDICATION(S)
KESIMPTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Active HBV infection.

REQUIRED MEDICAL INFORMATION
Documentation to show inadequate response, contraindication, or intolerance to 2 different agents used to treat MS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

L-GLUTAMINE ORAL POWDER

MEDICATION(S)
L-GLUTAMINE 5 GM PACKET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of sickle cell disease confirmed by chart notes (must be attached). Documentation that request is to reduce acute complications of sickle cell disease. Documentation of inadequate response to maximum tolerated dose of hydroxyurea therapy OR documented intolerance or contraindication to hydroxyurea therapy. Request is within the FDA labeled dose.

AGE RESTRICTION
5 years of age and older.

PRESCRIBER RESTRICTION
Hematologist or oncologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LANREOTIDE EXTENDED RELEASE

MEDICATION(S)
LANREOTIDE ACETATE, SOMATULINE DEPOT 60 MG/0.2ML SOLUTION, SOMATULINE DEPOT 90 MG/0.3ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of acromegaly. Baseline insulin-like growth factor-1 (IGF-1) level for age and/or gender is above the upper limit of normal based on laboratory reference range. The patient has had an inadequate response to surgery or radiation therapy OR there is a clinical reason why the patient has not had surgery or radiation therapy. Documented diagnosis of unresectable, well or moderately differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors. Documented diagnosis of carcinoid syndrome with symptoms of flushing and/or diarrhea.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: the patient has had a positive clinical response.

PART B PREREQUISITE
N/A

LIBERVANT

MEDICATION(S)
LIBERVANT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Acute narrow-angle glaucoma.

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis. Applies to new starts only.

AGE RESTRICTION
2 to 5 years of age.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist or pediatric specialist trained in management of epilepsy.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LIDOCAINE PATCHES

MEDICATION(S)
LIDOCAINE 5 % PATCH, LIDOCAN

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Diabetic peripheral neuropathy, cancer-related neuropathic pain.

EXCLUSION CRITERIA
Patients with a known history of sensitivity to local anesthetics of the amide type, or to any other component of the product.

REQUIRED MEDICAL INFORMATION
Documentation to confirm the diagnosis of pain associated with post-herpetic neuralgia, diabetic peripheral neuropathy, or cancer-related neuropathic pain.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

LIVTENCITY

MEDICATION(S)
LIVTENCITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrent use of ganciclovir or valganciclovir.

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis of active cytomegalovirus (CMV) infection or disease. Confirmation that the patient has undergone hematopoietic stem cell transplant or solid organ transplant. Confirmation of one of the following: (1) documentation showing infection or disease is refractory or resistant to treatment with one of the following: ganciclovir, valganciclovir, cidofovir, foscarnet, (2) documentation of an inadequate response, intolerance, or contraindication to one of the following: ganciclovir, valganciclovir, cidofovir, foscarnet, (3) documentation showing only Livtencity will be effective for CMV infection or disease.

AGE RESTRICTION
12 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a transplant specialist, infectious disease specialist, hematologist, or oncologist.

COVERAGE DURATION
2 months.

OTHER CRITERIA
For reauthorization: Confirmation that the patient has had a positive clinical response.

PART B PREREQUISITE
N/A

LUCEMYRA

MEDICATION(S)
LOFEXIDINE HCL, LUCEMYRA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of acute opioid withdrawal documented by an opioid withdrawal scale (such as Objective Opioid Withdrawal Scale [OOWS], Clinical Opioid Withdrawal Scale [COWS], Subjective Opioid Withdrawal Scale [SOWS]). Documentation must be attached. Documentation of an inadequate response, inability to tolerate, or contraindication to clonidine. If the request is for brand Lucemyra, documentation of inadequate response, intolerance, or contraindication to generic lofexidine.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
14 days.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MAVYRET

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients with moderate or severe hepatic impairment (Child-Pugh B or C) or those with any history of prior hepatic decompensation. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of chronic Hepatitis C (CHC). Lab results must be attached: Hepatitis C virus (HCV) genotype, quantitative HCV RNA, complete blood count (CBC), international normalized ratio (INR), hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels), transient elastography (such as FibroScan) or noninvasive serologic tests (such as FibroSure or calculate FIB-4 score), Hepatitis B surface antigen (HBsAg), and HIV antigen/antibody test. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
8 to 16 weeks. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

PART B PREREQUISITE

N/A

METYROSINE

MEDICATION(S)
METYROSINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Documentation of inadequate response, intolerance, or contraindication to a selective alpha-blocker (e.g., doxazosin, prazosin, terazosin).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MIFEPRISTONE

MEDICATION(S)
MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrent use of lovastatin, simvastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinine, sirolimus, tacrolimus. Concurrent use of systemic corticosteroids for life-saving purposes such as immunosuppression following organ transplant.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MIGLUSTAT

MEDICATION(S)
MIGLUSTAT, YARGESA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of mild to moderate type 1 Gaucher Disease (GD1). Enzyme replacement therapy is not a therapeutic option (e.g., due to allergy, hypersensitivity, or poor venous access).

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MYALEPT

MEDICATION(S)
MYALEPT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients with general obesity not associated with congenital leptin deficiency. Patients with HIV-related lipodystrophy. Patients with metabolic disease, including diabetes mellitus and hypertriglyceridemia, without concurrent evidence of congenital or acquired generalized lipodystrophy.

REQUIRED MEDICAL INFORMATION
Documentation showing confirmation of a diagnosis of congenital or acquired generalized lipodystrophy. Documentation of baseline labs (hemoglobin A1c, fasting plasma glucose, triglycerides).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Documentation showing benefit of treatment (as evidenced by decrease in at least one of the following: hemoglobin A1c, fasting glucose, and/or triglycerides).

PART B PREREQUISITE
N/A

NEXLETOL AND NEXLIZET

MEDICATION(S)
NEXLETOL, NEXLIZET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Documentation of prior treatment with statin therapy. Documentation discussing statin-associated side effects (rhabdomyolysis, muscle pain, muscle weakness associated with statin use) or contraindication (active liver disease, persistent elevation of serum transaminases) if statin therapy cannot be used. Documentation of prior treatment with ezetimibe therapy or intolerance/contraindication to ezetimibe. Documentation of baseline labs (lipid profile).

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Documentation of updated labs (lipid profile).

PART B PREREQUISITE
N/A

NORDITROPIN

MEDICATION(S)
NORDITROPIN FLEXPRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For children: (1) Growth failure due to growth hormone deficiency (GHD) diagnosed via clinical assessment of appropriate auxological findings documented and attached (such as growth chart, height, height velocity, chronological and bone age) and at least 1 of the following: (a) Subnormal response to at least 2 provocative growth hormone (GH) stimulation tests (resulting in peak GH levels less than 10ng/mL) OR (b) Subnormal response to at least 1 provocative GH stimulation test (resulting in peak GH level less than 10ng/mL) AND subnormal insulin-like growth factor-1 (IGF-1) level OR (c) Subnormal IGF-1 level AND panhypopituitarism, pituitary disease, hypothalamic disease, hypothalamic/pituitary surgery, radiation therapy, or trauma. (2) Short stature associated with Noonan Syndrome, Prader-Willi Syndrome, or Turner Syndrome with attached documentation of appropriate genetic testing and assessment of characteristic clinical manifestations. (3) For short stature born small for gestational age with no catch-up growth by age 2-4 years, chart notes confirming diagnosis. (4) Idiopathic Short Stature (ISS) with (a) documentation of a height standard deviation score (SDS) less than -2.25 and associated with growth rates unlikely to allow one to reach normal adult height and (b) documentation of growth chart, growth potential, impaired height velocity for age group, and bone age. For adults: (5) Diagnosis of adult GHD (a) as a result of childhood onset of GHD due to organic disease (attach documentation) or (b) adult onset as a result of pituitary or hypothalamic disease, panhypopituitarism, hypothalamic/pituitary surgery, radiation therapy, or trauma, (c) confirmation of adult GHD via subnormal IGF-1 prior to or while off of GH, and (d) If IGF-1 is questionable or uncertain, confirmation of adult GHD via a subnormal GH response to provocative testing prior to or while off of GH therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
RENEWAL REQUESTS: chart notes (for children include documentation of growth chart, height velocity, chronological age, bone age, and linear growth potential remaining with open epiphyses) and for children and adults, documentation that the patient has tolerated the medication and has a normal IGF-1 level or will have their growth hormone dose adjusted to attain a normal IGF-1 concentration.

PART B PREREQUISITE
N/A

NUEDEXTA

MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with quinidine, quinine, or mefloquine. Patients with a history of quinidine, quinine or mefloquine-induced thrombocytopenia, hepatitis, or other hypersensitivity reactions. Use with an MAOI or within 14 days of stopping an MAOI. Prolonged QT interval, congenital long QT syndrome, torsades de pointes, heart failure, or complete atrioventricular (AV) block without implanted pacemaker. Concomitant use with drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine or pimozide).

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis of pseudobulbar affect (PBA). For patients at risk of QT prolongation and torsades de pointes, baseline ECG and an ECG evaluation 3-4 hours after the first dose.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NUPLAZID

MEDICATION(S)
NUPLAZID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Parkinson’s disease. Documentation of symptoms of psychosis with at least one of the following: hallucinations or delusions. Documentation of an inadequate response, intolerance, or contraindication to at least one of the following: quetiapine or clozapine. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

NUZYRA

MEDICATION(S)
NUZYRA 100 MG RECON SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of community acquired bacterial pneumonia OR diagnosis of an acute bacterial skin and skin structure infection (ABSSSI). One of the following: (1) documentation of an inadequate response, intolerance, or contraindication to two antibiotics to which the organism is susceptible, (2) Nuzyra is the only antibiotic to which the organism is susceptible, (3) Therapy with Nuzyra was initiated in an inpatient setting.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with infectious disease specialist.

COVERAGE DURATION
14 days.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OCALIVA

MEDICATION(S)
OCALIVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients with decompensated cirrhosis (e.g., Child-Pugh Class B or C) or a prior decompensation event. Patients with compensated cirrhosis who have evidence of portal hypertension. Complete biliary obstruction.

REQUIRED MEDICAL INFORMATION
Chart notes that document the patient's diagnosis of primary biliary cholangitis (PBC) confirmed by two of the following: a positive antimitochondrial antibody test, elevated serum alkaline phosphatase level, liver biopsy, or ultrasound scan of the liver. Confirmation that the patient was taking UDCA for at least one year without response and will continue treatment with UDCA while on Ocaliva or is unable to tolerate UDCA. Labs documenting liver function (AST/ALT, alkaline phosphatase, total bilirubin) and lipid panel. For renewals, updated labs documenting liver function and lipid panel and confirmation showing disease improvement while on therapy.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Hepatologist or gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

OCTREOTIDE

MEDICATION(S)
OCTREOTIDE ACETATE 100 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 100 MCG/ML SOLUTION, OCTREOTIDE ACETATE 1000 MCG/ML SOLUTION, OCTREOTIDE ACETATE 200 MCG/ML SOLUTION, OCTREOTIDE ACETATE 50 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 50 MCG/ML SOLUTION, OCTREOTIDE ACETATE 500 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 500 MCG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of acromegaly. Baseline insulin-like growth factor-1 (IGF-1) level for age and/or gender is above the upper limit of normal based on laboratory reference range. The patient has had an inadequate response to surgery or radiation therapy OR there is a clinical reason why the patient has not had surgery or radiation therapy. Documented diagnosis of metastatic carcinoid tumor. Patient requiring symptomatic treatment of severe diarrhea or flushing episodes. Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist, oncologist, or gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: the patient has had a positive clinical response.

PART B PREREQUISITE

N/A

OFEV

MEDICATION(S)
OFEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation showing a diagnosis of idiopathic pulmonary fibrosis OR documentation showing a diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype OR documentation showing that the medication will be used to slow the rate of decline in pulmonary function in patients with a diagnosis of systemic sclerosis-associated interstitial lung disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a pulmonologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ORAL ONCOLOGY AGENTS

MEDICATION(S)

AKEEGA, ALECENSA, ALUNBRIG, AUGTYRO, AYVAKIT, BALVERSA, BEXAROTENE 75 MG CAP, BOSULIF, BRAFTOVI, BRUKINSA, CABOMETYX, CALQUENCE, CAPRELSA, COMETRIQ (100 MG DAILY DOSE), COMETRIQ (140 MG DAILY DOSE), COMETRIQ (60 MG DAILY DOSE), COPIKTRA, COTELLIC, DANZITEN, DASATINIB, DAURISMO, ERIVEDGE, ERLOTINIB HCL, EVEROLIMUS 10 MG TAB, EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 3 MG TAB SOL, EVEROLIMUS 5 MG TAB, EVEROLIMUS 5 MG TAB SOL, EVEROLIMUS 7.5 MG TAB, FOTIVDA, FRUZAQLA, GAVRETO, GEFITINIB, GILOTRIF, GLEOSTINE, IBRANCE, ICLUSIG, IDHIFA, IMATINIB MESYLATE, IMBRUVICA 140 MG CAP, IMBRUVICA 140 MG TAB, IMBRUVICA 280 MG TAB, IMBRUVICA 420 MG TAB, IMBRUVICA 70 MG CAP, IMBRUVICA 70 MG/ML SUSPENSION, IMKELDI, INLYTA, INQOVI, INREBIC, ITOVEBI, IWILFIN, JAKAFI, JAYPIRCA, KISQALI (200 MG DOSE), KISQALI (400 MG DOSE), KISQALI (600 MG DOSE), KISQALI FEMARA (200 MG DOSE), KISQALI FEMARA (400 MG DOSE), KISQALI FEMARA (600 MG DOSE), KOSELUGO, KRAZATI, LAPATINIB DITOSYLATE, LAZCLUZE, LENALIDOMIDE, LENVIMA (10 MG DAILY DOSE), LENVIMA (12 MG DAILY DOSE), LENVIMA (14 MG DAILY DOSE), LENVIMA (18 MG DAILY DOSE), LENVIMA (20 MG DAILY DOSE), LENVIMA (24 MG DAILY DOSE), LENVIMA (4 MG DAILY DOSE), LENVIMA (8 MG DAILY DOSE), LONSURF, LORBRENA, LUMAKRAS, LYNPARZA, LYTGOBI (12 MG DAILY DOSE), LYTGOBI (16 MG DAILY DOSE), LYTGOBI (20 MG DAILY DOSE), MEKINIST, MEKTOVI, NERLYNX, NINLARO, ODOMZO, OGSIVEO, OJEMDA, OJJAARA, ONUREG, ORGOVYX, ORSERDU, PAZOPANIB HCL, PEMAZYRE, PIQRAY (200 MG DAILY DOSE), PIQRAY (250 MG DAILY DOSE), PIQRAY (300 MG DAILY DOSE), POMALYST, QINLOCK, RETEVMO, REVUFORJ, REZLIDHIA, ROZLYTREK, RUBRACA, RYDAPT, SCEMBLIX, SORAFENIB TOSYLATE, SPRYCEL, STIVARGA, SUNITINIB MALATE, TABRECTA, TAFINLAR, TAGRISSO, TALZENNA, TASIGNA, TAZVERIK, TEPMETKO, THALOMID, TIBSOVO, TORPENZ, TRUQAP, TUKYSA, TURALIO 125 MG CAP, VANFLYTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VONJO, VORANIGO, WELIREG, XALKORI, XOSPATA, XPOVIO (100 MG ONCE WEEKLY) 50 MG TAB THPK, XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK, XPOVIO (40 MG TWICE WEEKLY) 40 MG TAB THPK, XPOVIO (60 MG ONCE WEEKLY) 60 MG TAB THPK, XPOVIO (60 MG TWICE WEEKLY), XPOVIO (80 MG ONCE WEEKLY) 40 MG TAB THPK, XPOVIO (80 MG TWICE WEEKLY), ZEJULA 100 MG TAB, ZEJULA 200 MG TAB, ZEJULA 300 MG TAB, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA

PA INDICATION INDICATOR

3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

OTEZLA

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with other disease-modifying antirheumatic drugs (DMARDs).

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis. For active psoriatic arthritis and plaque psoriasis: Documentation showing a trial of, intolerance to, or contraindication to at least one DMARD indicated for the diagnosis. For oral ulcers associated with Behcets Disease: Documentation showing a trial of, intolerance to, or contraindication to colchicine.

AGE RESTRICTION
6 years of age and older for treatment of plaque psoriasis, 18 years or older for treatment of psoriatic arthritis or Behcets Disease.

PRESCRIBER RESTRICTION
Psoriatic arthritis: dermatologist or rheumatologist. Plaque psoriasis: dermatologist. Behcets Disease: rheumatologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

OXERVATE

MEDICATION(S)
OXERVATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Ophthalmologist.

COVERAGE DURATION
8 weeks.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PANRETIN

MEDICATION(S)
PANRETIN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatologist, oncologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PART D INSULIN SUPPLIES

MEDICATION(S)
BD ALCOHOL PADS, GAUZE PADS & DRESSINGS - PADS 2 X 2, INSULIN PEN NEEDLE (NOVO/BD/ULTIMED/OWEN/TRIVIDIA), INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC), INSULIN SYRINGE (DISP) U-100 1 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC) , INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/ULTIMED/ALLISON/TRIVIDIA/MHC), ISOPROPYL ALCOHOL 0.7 ML/ML MEDICATED PAD, NEEDLES, INSULIN DISP., SAFETY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation showing that the member is diagnosed with diabetes mellitus. Documentation showing the patient will be using the requested product for the purpose of delivering insulin to the body. Prior authorization does not apply to patients who have filled insulin in the last 180 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, AMINOSYN II 10 % SOLUTION, AMINOSYN-PF, AMPHOTERICIN B 50 MG RECON SOLN, AMPHOTERICIN B LIPOSOME, APREPITANT, ARFORMOTEROL TARTRATE, AVASTIN, AZACITIDINE, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE SODIUM, BORTEZOMIB 3.5 MG RECON SOLN, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CARBOPLATIN, CINACALCET HCL, CISPLATIN 100 MG/100ML SOLUTION, CISPLATIN 200 MG/200ML SOLUTION, CISPLATIN 50 MG/50ML SOLUTION, CLINIMIX/DEXTROSE (4.25/10), CLINIMIX/DEXTROSE (4.25/5), CLINIMIX/DEXTROSE (5/15), CLINIMIX/DEXTROSE (5/20), CLINISOL SF, CLINOLIPID, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE 50 MG/ML SOLUTION, CYCLOSPORINE MODIFIED, DOCETAXEL, ELIGARD, ENGERIX-B, ENVARSUS XR, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, FIRMAGON, FIRMAGON (240 MG DOSE), FLUOROURACIL 1 GM/20ML SOLUTION, FLUOROURACIL 2.5 GM/50ML SOLUTION, FLUOROURACIL 5 GM/100ML SOLUTION, FLUOROURACIL 500 MG/10ML SOLUTION, FORMOTEROL FUMARATE 20 MCG/2ML NEBU SOLN, FREAMINE III, FULVESTRANT, GENGRAF, GRANISETRON HCL 1 MG TAB, HEPLISAV-B, HERCEPTIN HYLECTA, INFLECTRA, INTRALIPID, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, IRINOTECAN HCL, JYNNEOS, KADCYLA, KANJINTI, KEYTRUDA, LEUPROLIDE ACETATE 1 MG/0.2ML KIT, LEUPROLIDE ACETATE (3 MONTH), LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT (4-MONTH), LUPRON DEPOT (6-MONTH), LUPRON DEPOT-PED (1-MONTH), LUPRON DEPOT-PED (3-MONTH), LUPRON DEPOT-PED (6-MONTH), MVASI, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG RECON SOLN, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE MOFETIL HCL, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NULOJIX, NUTRILIPID, OGIVRI, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, ONDANSETRON HCL ORAL SOLN 4 MG/5ML,

OXALIPLATIN 100 MG RECON SOLN, OXALIPLATIN 100 MG/20ML SOLUTION, OXALIPLATIN 50 MG RECON SOLN, OXALIPLATIN 50 MG/10ML SOLUTION, PACLITAXEL, PACLITAXEL PROTEIN-BOUND PART, PARAPLATIN, PENTAMIDINE ISETHIONATE FOR NEBULIZATION SOLN 300 MG, PLENAMINE, PREHEVBRIO, PREMASOL, PROCRIT, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PROSOL, PULMOZYME, RECOMBIVAX HB, RENFLEXIS, RETACRIT, RUXIENCE, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 2 MG TAB, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TOBRAMYCIN 300 MG/5ML NEBU SOLN, TPN ELECTROLYTES, TRAVASOL, TRAZIMERA, TRELSTAR MIXJECT, TROPHAMINE, TRUXIMA, YUPELRI, ZIRABEV, ZOLEDRONIC ACID 4 MG/5ML CONC, ZOLEDRONIC ACID 5 MG/100ML SOLUTION

DETAILS

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

PEGFILGRASTIM AGENTS

MEDICATION(S)
FULPHILA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For primary prophylaxis of febrile neutropenia: Documentation that shows that patient is receiving myelosuppressive chemotherapy. Documentation that shows that patient is at increased risk for febrile neutropenia. Documentation that shows that patient is receiving dose-dense or high-dose chemotherapy. For secondary prophylaxis of febrile neutropenia: documentation that shows the patient is receiving myelosuppressive chemotherapy with a history of febrile neutropenia during previous course of chemotherapy (for which primary prophylaxis was not received). For all diagnoses, confirmation that lab work (complete blood count with differential including ANC) is being monitored.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PHOSPHODIESTERASE 5 INHIBITORS

MEDICATION(S)
ALYQ, SILDENAFIL CITRATE 20 MG TAB, TADALAFIL (PAH)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant organic nitrates. Concomitant Guanylate Cyclase (GC) Stimulators.

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis of pulmonary arterial hypertension (PAH) WHO Group 1. Diagnosis confirmed by a complete right heart catheterization (RHC). PAH defined as a resting mean pulmonary artery pressure (mPAP) of greater than 20 mmHg, pulmonary capillary wedge pressure (PCWP) of less than or equal to 15 mmHg, and pulmonary vascular resistance (PVR) of greater than 3 Wood units (RHC results must be provided). For Raynaud’s phenomenon: Confirmation of an inadequate response or intolerance to one calcium channel blocker.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a cardiologist, pulmonologist, practitioner at a Pulmonary Hypertension Association-Accredited center, or rheumatologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PIRFENIDONE

MEDICATION(S)
PIRFENIDONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Other known causes of interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity, Hermansky-Pudlak syndrome, familial idiopathic pulmonary fibrosis, and chronic hypersensitivity pneumonitis).

REQUIRED MEDICAL INFORMATION
Initial request: Documented diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by usual interstitial pneumonia (UIP) pattern present on high resolution computed tomography (HRCT) in patients without lung biopsy, or the combination of HRCT and biopsy pattern in patients with lung biopsy. Documented forced vital capacity (FVC) greater than or equal to 50%. Documented baseline liver function tests (ALT, AST, and bilirubin) and documentation that liver function tests (ALT, AST, and bilirubin) will be monitored periodically throughout the course of treatment as clinically necessary. For ongoing therapy: Documentation of rationale for continued IPF therapy (e.g., stability or improvement in the rate of decline for FVC, IPF symptoms, or other prescriber-assessed benefit of therapy). Confirmation that liver function tests (ALT, AST, and bilirubin) are being monitored periodically throughout the course of treatment as clinically indicated.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a pulmonologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

POSACONAZOLE

MEDICATION(S)
POSACONAZOLE 100 MG TAB DR, POSACONAZOLE 40 MG/ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients with known hypersensitivity to posaconazole or other azole antifungal agents. Concurrent use with sirolimus, CYP3A4 substrates (pimozide, quinidine), HMG-CoA reductase inhibitors primarily metabolized through CYP3A4, ergot alkaloids, or venetoclax.

REQUIRED MEDICAL INFORMATION
Documentation of use for treatment of invasive Aspergillosis OR prophylaxis of invasive Aspergillus and Candida infections in severely immunocompromised patients (hematopoietic stem cell transplant (HSCT) recipients with graft-versus host-disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy) OR diagnosis of oropharyngeal candidiasis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREGABALIN ER

MEDICATION(S)
PREGABALIN ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation to confirm the diagnosis of pain associated with post-herpetic neuralgia (PHN) or diabetic peripheral neuropathy (DPN). Documentation of an inadequate response or inability to tolerate gabapentin and immediate release Lyrica. Dosage prescribed within package insert requirements (maximum of 330 mg per day for DPN, maximum of 660 mg per day for PHN).

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREVYMIS

MEDICATION(S)
PREVYMIS 240 MG TAB, PREVYMIS 480 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant (HSCT): 1) the patient is CMV-seropositive, AND 2) the patient is a recipient of an allogeneic HSCT. For prophylaxis of CMV disease in kidney transplant: 1) the patient is CMV-seronegative, AND 2) the patient is a high-risk recipient of kidney transplant where donor is CMV seropositive.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
7 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PYRIMETHAMINE

MEDICATION(S)
PYRIMETHAMINE 25 MG TAB

PA INDICATION INDICATOR
4 - All FDA-Approved Indications, Some Medically-Accepted Indications

OFF LABEL USES
Primary and secondary prophylaxis of toxoplasmosis in patients with HIV, Prophylaxis of pneumocystis jirovecii pneumonia in patients with HIV.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For all diagnoses: Documentation of an inadequate response, intolerance, or contraindication to trimethoprim-sulfamethoxazole. For acute treatment of toxoplasmosis: Confirmation of severe or prolonged symptoms that warrants treatment. For primary prophylaxis of toxoplasmosis gondii (T. gondii) infection all of the following: (1) Confirmed diagnosis of HIV, (2) Documentation of CD4 count less than 100 cells/mm*3, AND (3) T. gondii IgG positive. For secondary prophylaxis of toxoplasmosis gondii infection all of the following: (1) Confirmed diagnosis of HIV, (2) CD4 count less than 200 cells/mm*3. For primary prophylaxis of Pneumocystis jirovecii pneumonia: (1) Confirmed diagnosis of HIV, (2) CD4 count less than 200 cells/mm*3.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with infectious disease specialist.

COVERAGE DURATION
For acute treatment of toxoplasmosis: 1 month. For all other diagnoses: 12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

QUININE

MEDICATION(S)
QUININE SULFATE 324 MG CAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Treatment or prevention of leg cramps.

REQUIRED MEDICAL INFORMATION
One of the following: Documentation of diagnosis of uncomplicated Plasmodium falciparum malaria with confirmation of chloroquine resistance. Or, documentation of diagnosis of babesiosis and quinine will be used in combination with clindamycin.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 month.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RAVICTI

MEDICATION(S)
RAVICTI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Not indicated for the treatment of acute hyperammonemia in patients with UCDs nor for the treatment of N-acetylglutamate synthase (NAGS) deficiency. Concomitant use with another phenylbutyrate product (like sodium phenylbutyrate).

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis by enzymatic, biochemical, or genetic testing attached. Documentation of inadequate response, intolerance, or contraindication to sodium phenylbutyrate. Confirmation that ammonia concentration and serum amino acids are and will continue to be monitored to ensure positive clinical treatment response.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a metabolic or medical genetic specialist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RECORLEV

MEDICATION(S)
RECORLEV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of Cushing’s Syndrome. Notes showing the member is being treated for endogenous hypercortisolemia (e.g., pituitary tumor, ectopic tumor, adrenal adenoma, or carcinoma). Notes showing that the member is not a candidate for surgery OR has recurrent hypercortisolism after initial surgery. Documentation showing a trial of, intolerance to, or contraindication to ketoconazole.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: confirmation of positive clinical response.

PART B PREREQUISITE
N/A

REGRANEX

MEDICATION(S)
REGRANEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation to confirm the diagnosis for use on lower extremity diabetic neuropathic ulcers.

AGE RESTRICTION
16 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
5 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REPATHA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

REZUROCK

MEDICATION(S)
REZUROCK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Pregnancy.

REQUIRED MEDICAL INFORMATION
If female of childbearing age or male with female partners of reproductive potential, confirmation that effective contraception will be used during treatment. Confirmation of a trial and failure of at least 2 conventional systemic treatments for chronic graft-versus-host disease.

AGE RESTRICTION
12 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

RINVOQ

MEDICATION(S)
RINVOQ, RINVOQ LQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Severe hepatic impairment. Active, serious infection. Live vaccines. Concomitant use with Janus kinase (JAK) inhibitor, biologic disease modifying anti-rheumatic drugs (DMARDs), potent immunosuppressant drugs, strong cytochrome P450 3A4 (CYP3A4) inducers, biologic immunomodulators, or biological therapies for ulcerative colitis.

REQUIRED MEDICAL INFORMATION
For a documented diagnosis of moderately to severely active rheumatoid arthritis (RA), active psoriatic arthritis (PsA), moderately to severely active ulcerative colitis (UC), active ankylosing spondylitis (AS), active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation, moderately to severely active Crohn’s disease (CD), or polyarticular juvenile idiopathic arthritis (pJIA): attach documentation of inadequate response or intolerance to at least one TNF blocker. For a documented diagnosis of refractory, moderate to severe atopic dermatitis (AD), attach a documented history of inadequate control with at least one other systemic drug (including biologics) used to treat refractory, moderate to severe atopic dermatitis OR documentation explaining why these drugs are inadvisable. For all diagnoses: confirmation that recent tuberculin testing is negative for latent tuberculosis infection or positive for latent tuberculosis with confirmation that treatment is completed or is receiving treatment for latent tuberculosis. Confirmation that liver function will be monitored with focus on elevated liver enzymes (ALT or AST). Confirmation that a complete blood count with differential does not show an absolute lymphocyte count less than 500 cells/mm3, absolute neutrophil count less than 1000 cells/mm3, or hemoglobin level less than 8g/dL.

AGE RESTRICTION
RINVOQ - 12 years of age and older for AD and 18 years and older for AS, CD, RA, UC and nr-axSpA.
RINVOQ / RINVOQ LQ – 2 years of age and older for pJIA and PsA.

PRESCRIBER RESTRICTION

Prescribed by or in consultation with the appropriate specialist based on diagnosis: a gastroenterologist, rheumatologist, or dermatologist.

COVERAGE DURATION

12 months.

OTHER CRITERIA

For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

RUFINAMIDE

MEDICATION(S)
RUFINAMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Lennox-Gastaut Syndrome (LGS). Documentation showing rufinamide will be used as adjunctive therapy. Documentation of an inadequate response, intolerance, or contraindication to at least one of the following: valproic acid derivatives, lamotrigine, clobazam, topiramate, cannabidiol (pharmaceutical). Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SAPROPTERIN

MEDICATION(S)
JAVYGTOR, SAPROPTERIN DIHYDROCHLORIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: Documented diagnosis of phenylketonuria confirmed by blood phenylalanine concentrations with labs attached. For reauthorization: The patient has had a positive clinical response, such as cognitive and/or behavioral improvements.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 3 months. Reauthorization: 12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SIGNIFOR

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of Cushing’s disease and ONE of the following: patient is not a candidate for pituitary surgery OR pituitary surgery has not been curative.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: confirmation of decrease in urinary free cortisol levels from baseline.

PART B PREREQUISITE
N/A

SIRTURO

MEDICATION(S)
SIRTURO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of pulmonary multi-drug resistant tuberculosis (MDR-TB). Documentation that Sirturo is being used in combination with at least 3 other medications to which the patient's MDR-TB isolate has been shown to be susceptible in vitro. If in vitro testing results are unavailable, Sirturo is being used in combination with at least 4 other medications to which the patient's MDR-TB isolate is likely to be susceptible.

AGE RESTRICTION
5 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an infectious disease specialist.

COVERAGE DURATION
24 weeks.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SIVEXTRO

MEDICATION(S)
SIVEXTRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of an acute bacterial skin and skin structure infection (ABSSSI) and ONE of the following: (1) documentation of an inadequate response, intolerance, or contraindication to two antibiotics to which the organism is susceptible, (2) Sivextro is the only antibiotic to which the organism is susceptible, or (3) Therapy with Sivextro was initiated in an inpatient setting.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with infectious disease specialist.

COVERAGE DURATION
6 days.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SKYRIZI

MEDICATION(S)
SKYRIZI, SKYRIZI PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Active, serious infection. Live vaccines.

REQUIRED MEDICAL INFORMATION
For plaque psoriasis: Confirmed diagnosis of moderately to severely active plaque psoriasis supported by clinical documentation. Documentation of inadequate response, intolerance, or contraindication to methotrexate or UVB therapy (alone or in combination with other medications) or acitretin. For psoriatic arthritis: Confirmed diagnosis of active psoriatic arthritis supported by clinical documentation. Documentation of inadequate response, intolerance, or contraindication to at least one DMARD. For moderately to severely active Crohn's disease: Confirmed diagnosis of moderately to severely active Crohn's disease supported by clinical documentation. Documentation of inadequate response, intolerance, or contraindication to one of the following: corticosteroids, methotrexate, or azathioprine. For moderately to severely active ulcerative colitis: Confirmed diagnosis of moderately to severely active ulcerative colitis supported by clinical documentation. Documentation of inadequate response, intolerance, or contraindication to one of the following: corticosteroids, azathioprine, 6-MP or methotrexate. For all diagnoses: Documentation of tuberculin testing that is negative for latent tuberculosis infection or positive for latent tuberculosis with documentation that treatment is completed or is receiving treatment for latent tuberculosis.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA

For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

SODIUM OXYBATE

MEDICATION(S)
SODIUM OXYBATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with sedative hypnotics. Succinic semialdehyde dehydrogenase deficiency.

REQUIRED MEDICAL INFORMATION
Documentation showing a diagnosis of excessive daytime sleepiness or cataplexy with narcolepsy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or sleep specialist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SODIUM PHENYLBUTYRATE

MEDICATION(S)
SODIUM PHENYLBUTYRATE 3 GM/TSP POWDER, SODIUM PHENYLBUTYRATE 500 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Treatment of acute hyperammonemia in urea cycle disorders.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of urea cycle disorder involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS) confirmed by enzymatic, biochemical, or genetic testing. Confirmation showing sodium phenylbutyrate will be used for chronic management.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with prescriber experienced in metabolic disorders.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

SOFOSBUVIR/VELPATASVIR

MEDICATION(S)
EPCLUSA, SOFOSBUVIR-VELPATASVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of chronic Hepatitis C (CHC). Lab results must be attached: Hepatitis C virus (HCV) genotype, quantitative HCV RNA, complete blood count (CBC), international normalized ratio (INR), hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels), transient elastography (such as FibroScan) or noninvasive serologic tests (such as FibroSure or calculate FIB-4 score), Hepatitis B surface antigen (HBsAg), and HIV antigen/antibody test. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 to 24 weeks. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

PART B PREREQUISITE
N/A

SOMAVERT

MEDICATION(S)
SOMAVERT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of acromegaly. Baseline insulin-like growth factor-1 (IGF-1) level for age and/or gender is above the upper limit of normal based on laboratory reference range. The patient has had an inadequate response to surgery or radiation therapy OR there is a clinical reason why the patient has not had surgery or radiation therapy. Documentation of an inadequate response, intolerance, or contraindication to octreotide.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: the patient has had a positive clinical response.

PART B PREREQUISITE
N/A

STELARA

MEDICATION(S)
STELARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Active, serious infection. Live vaccines.

REQUIRED MEDICAL INFORMATION
For initial requests: Confirmation of diagnosis of moderate to severe plaque psoriasis in patients who are candidates for phototherapy or systemic therapy, active psoriatic arthritis, moderately to severely active Crohn's disease, moderately to severely active ulcerative colitis. For plaque psoriasis: For patients 6 to 17 years of age: documentation of an inadequate response, intolerance, or contraindication to Enbrel. For patients 18 years of age and older: documentation of an inadequate response, intolerance, or contraindication to two of the following: Enbrel, an adalimumab containing product, Skyrizi, Otezla. For psoriatic arthritis: For patients 6 to 17 years of age: documentation of an inadequate response, intolerance, or contraindication to Enbrel. For patients 18 years of age and older: documentation of an inadequate response, intolerance, or contraindication to two of the following: Enbrel, an adalimumab containing product, Skyrizi, Otezla, Xeljanz/Xeljanz XR. For Crohn's disease: documentation of an inadequate response, intolerance, or contraindication to an adalimumab containing product and Skyrizi. For ulcerative colitis: inadequate response, intolerance, or contraindication to an adalimumab containing product and Xeljanz/Xeljanz XR. For all indications: Documentation of tuberculosis (TB) testing that is negative for latent tuberculosis infection or positive for latent tuberculosis with documentation that treatment is completed or is receiving treatment for latent tuberculosis.

AGE RESTRICTION
For plaque psoriasis and psoriatic arthritis: 6 years of age or older. For Crohn's disease and ulcerative colitis: 18 years of age or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist.

COVERAGE DURATION

12 months.

OTHER CRITERIA

For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

SYMPAZAN

MEDICATION(S)
SYMPAZAN

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of an inadequate response or inability to tolerate generic clobazam. Documentation showing that Sympazan will be used as adjunctive therapy to other antiepileptic drugs. Applies to new starts only.

AGE RESTRICTION
2 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TADALAFIL BPH

MEDICATION(S)
TADALAFIL 2.5 MG TAB, TADALAFIL 5 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant organic nitrates. Concomitant Guanylate Cyclase (GC) Stimulators. Treatment of erectile dysfunction (ED) in the absence of benign prostatic hyperplasia (BPH).

REQUIRED MEDICAL INFORMATION
Documentation showing a diagnosis of benign prostatic hyperplasia (BPH). Confirmation of an inadequate response or inability to tolerate at least one alpha blocker (such as tamsulosin, silodosin, alfuzosin) AND confirmation of an inadequate response or inability to tolerate at least one 5-alpha-reductase inhibitor (such as dutasteride, finasteride).

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TALTZ

MEDICATION(S)
TALTZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrent therapy with biologic DMARDs or tumor necrosis factor antagonists.

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis of moderate-to-severe plaque psoriasis (PsO), active psoriatic arthritis (PsA), active ankylosing spondylitis (AS) or non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation. For PsO: in pediatric patients ages 6-17 years, documentation of an inadequate response, intolerance, or contraindication to Enbrel and in adults with PsO documentation of inadequate response, intolerance, or contraindication to Enbrel, an adalimumab containing product, Otezla, or Skyrizi. For PsA: documentation of inadequate response, intolerance, or contraindication to Enbrel, an adalimumab containing product, Otezla, Rinvoq, Skyrizi, or Xeljanz/Xeljanz XR. For AS: documentation of inadequate response, intolerance, or contraindication: Enbrel, an adalimumab containing product, Rinvoq, or Xeljanz/Xeljanz XR. For nr-axSpA: documentation of inadequate response, intolerance, or contraindication to Rinvoq. For all indications: Confirmation of tuberculosis (TB) screening results and treatment plan for active or latent infection.

AGE RESTRICTION
For moderate-to-severe PsO: 6 years of age or older. For active PsA, active AS and nr-axSpA: 18 years of age or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a rheumatologist or dermatologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA

For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

TASIMELTEON

MEDICATION(S)
HETLIOZ LQ, TASIMELTEON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For Non-24-Hour Sleep-Wake Disorder (Non-24): Documentation of diagnosis of complete blindness. Documentation of diagnosis of Non-24 indicated by actigraphy or sleep log or diary. Documentation of baseline nighttime sleep time and daytime naptime per sleep log or diary. For nighttime sleep disturbances in Smith-Magens Syndrome (SMS): Documentation of diagnosis confirmed by genetic testing. Documentation of sleep disturbances.

AGE RESTRICTION
Capsules: 16 years of age and older. Oral suspension: 3 to 15 years of age.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a sleep specialist, psychiatrist, or neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization for Non-24: Documentation of response indicated by improvement in nighttime sleep time or reduction in daytime naptime compared to baseline per sleep log or diary. For renewal for nighttime sleep disturbances in Smith-Magens Syndrome (SMS): Documentation of response indicated by improvement in sleep disturbances including difficulty falling asleep, problems staying asleep, and frequent awakenings at night as documented per chart notes.

PART B PREREQUISITE

N/A

TAVNEOS

MEDICATION(S)
TAVNEOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]). Used as adjunct to standard therapy OR in combination with standard therapy (e.g., rituximab, cyclophosphamide, mycophenolate, azathioprine, and/or glucocorticoids).

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist.

COVERAGE DURATION
6 months initial. 12 months reauthorization.

OTHER CRITERIA
For reauthorization: confirmation of disease stability or improvement.

PART B PREREQUISITE
N/A

TERIPARATIDE

MEDICATION(S)
TERIPARATIDE (RECOMBINANT) 620 MCG/2.48ML SOLN PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of osteoporosis (primary or hypogonadal in men, glucocorticoid-induced or postmenopausal in women). Baseline labs (T-score). Documentation of an inadequate response or inability to tolerate at least one of the following: bisphosphonates, hormone replacement therapy, selective-estrogen receptor modulators (SERMs) or Denosumab (Prolia).

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization, one of the following: Cumulative lifetime therapy does not exceed 2 years OR member remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones.

PART B PREREQUISITE
N/A

TETRABENAZINE

MEDICATION(S)
TETRABENAZINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Congenital long QT syndrome. History of cardiac arrhythmias. Hepatic impairment. Concurrent use of MAO inhibitors. Concurrent use of reserpine, deutetrabenazine, or valbenazine. Actively suicidal patients and patients with untreated or inadequately treated depression.

REQUIRED MEDICAL INFORMATION
Documentation showing that other movement disorders (such as Tardive Dyskinesia or Parkinsons disease) have been excluded with documentation attached. Documentation showing confirmation of a diagnosis of Chorea associated with Huntingtons Disease with documentation attached.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist or psychiatrist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Documented improvement in symptoms of Chorea with medical records attached.

PART B PREREQUISITE
N/A

TOPICAL RETINOIDS

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

TOPICAL TESTOSTERONE PRODUCTS

MEDICATION(S)
TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 20.25 MG/ACT (1.62%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) GEL, TESTOSTERONE 50 MG/5GM (1%) GEL, TESTOSTERONE TD GEL PUMP 20.25 MG/ACT (1.62%)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Men with carcinoma of the breast or known or suspected prostate cancer. Women who are pregnant.

REQUIRED MEDICAL INFORMATION
Documentation confirming diagnosis. For hypogonadism: Confirmed low testosterone levels in comparison to lab reference values on two separate occasions. Explanation of symptoms experienced as a result of testosterone deficiency.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Evaluation of response to testosterone therapy.

PART B PREREQUISITE
N/A

UPTRAVI

MEDICATION(S)
UPTRAVI 1000 MCG TAB, UPTRAVI 1200 MCG TAB, UPTRAVI 1400 MCG TAB, UPTRAVI 1600 MCG TAB, UPTRAVI 200 & 800 MCG TAB THPK, UPTRAVI 200 MCG TAB, UPTRAVI 400 MCG TAB, UPTRAVI 600 MCG TAB, UPTRAVI 800 MCG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concurrent use with strong inhibitors of CYP2C8 (e.g., gemfibrozil).

REQUIRED MEDICAL INFORMATION
Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH) WHO Group 1 with New York Heart Association (NYHA) Functional Class II-III by complete right catheterization (RHC) with results attached. Mean pulmonary artery pressure (mPAP) greater than 20 mmHg, pulmonary vascular resistance (PVR) greater than 3 wood units, and a pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. Pharmacy records or chart notes documenting trial of or inadequate response to two alternatives (used alone or in combination) from the following list of medications: endothelin receptor antagonists (bosentan, ambrisentan, macitentan), phosphodiesterase-5 inhibitors (sildenafil, tadalafil), guanylate cyclase stimulators (riociguat). Clarify there is a treatment plan. Chart notes that document required lab monitoring [hepatic impairment status (Child Pugh Class)] and dosing adjustments as needed.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a cardiologist, pulmonologist, or practitioner at a Pulmonary Hypertension Association-Accredited center.

COVERAGE DURATION
12 months.

OTHER CRITERIA

N/A

PART B PREREQUISITE

N/A

VALCHLOR

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma. Documentation of an inadequate response, intolerance, or contraindication to at least one prior skin-directed therapy (e.g. topical corticosteroids, topical retinoids, topical imiquimod). Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VERQUVO

MEDICATION(S)
VERQUVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of symptomatic chronic heart failure with NYHA Class II to IV. The patient has a left ventricular ejection fraction (LVEF) less than 45 percent. For initial therapy, the patient meets ONE of the following: (1) hospitalization for heart failure within the past 6 months OR (2) use of outpatient intravenous diuretics for heart failure within the past 3 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: patient has had a positive clinical response to therapy.

PART B PREREQUISITE
N/A

VIGABATRIN

MEDICATION(S)
VIGABATRIN, VIGADRONE, VIGPODER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of refractory complex partial seizures or infantile spasms. For refractory complex partial seizures: documentation that vigabatrin is being used as adjunctive therapy AND documentation of an inadequate response, intolerance, or contraindication to two antiepileptic agents such as: carbamazepine, divalproex, gabapentin, lacosamide, lamotrigine, levetiracetam, oxcarbazepine, topiramate, zonisamide. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VORICONAZOLE

MEDICATION(S)
VORICONAZOLE 200 MG RECON SOLN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

VOWST

MEDICATION(S)
VOWST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Active Clostridioides difficile infection (CDI).

REQUIRED MEDICAL INFORMATION
Documentation to confirm Vowst is being used to prevent the recurrence of CDI. The patient has experienced at least 2 recurrent CDIs. The patient has or will complete CDI standard of care treatment (defined as 10-21 days of treatment with vancomycin and/or fidaxomicin) 2-4 days prior to initiating treatment with Vowst. The patient has or will complete a bowel prep and will not eat or drink for at least 8 hours prior to the first dose.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist or infectious disease specialist.

COVERAGE DURATION
30 days.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

WAKEFULNESS-PROMOTING AGENTS

MEDICATION(S)
ARMODAFINIL, MODAFINIL 100 MG TAB, MODAFINIL 200 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
A confirmed diagnosis of either narcolepsy (with sleep study attached), obstructive sleep apnea (with sleep study attached), or shift work disorder.

AGE RESTRICTION
17 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XCOPRI

MEDICATION(S)
XCOPRI, XCOPRI (250 MG DAILY DOSE) 100 & 150 MG TAB THPK, XCOPRI (350 MG DAILY DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of partial-onset seizures. Documentation of an inadequate response, intolerance, or contraindication to two of the following drugs: carbamazepine, divalproex, gabapentin, lacosamide, lamotrigine, levetiracetam, oxcarbazepine, topiramate. Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XDEMVY

MEDICATION(S)
XDEMVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 weeks.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XELJANZ

MEDICATION(S)
XELJANZ, XELJANZ XR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with other biologic Disease Modifying Anti-Rheumatic Drugs (DMARDs) or potent immunosuppressants.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Documentation of tuberculosis screening results and treatment plan for active or latent infection. For all diagnoses, RA, PsA, AS, UC, pcJIA, documentation of an inadequate response or intolerance to at least one TNF blocker indicated to treat the diagnosis.

AGE RESTRICTION
2 years and older for polyarticular course juvenile idiopathic arthritis. 18 years and older for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, and ulcerative colitis.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a rheumatologist or gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

XERMELO

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of carcinoid syndrome diarrhea (CSD). Notes showing diarrhea is inadequately controlled by at least a 3-month trial of somatostatin analog therapy (SSA). Must provide documentation showing average of at least 4 bowel movements per day despite use of SSA therapy (e.g. Sandostatin LAR Depot). Must have records confirming concurrent SSA therapy.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation of positive clinical response to therapy.

PART B PREREQUISITE
N/A

XGEVA

MEDICATION(S)
XGEVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients currently being treated with Prolia.

REQUIRED MEDICAL INFORMATION
Subject to Part B vs Part D review. INITIAL: Documentation Xgeva will be used for one the following: prevention of skeletal-related events in patients with multiple myeloma and patients with bone metastases from solid tumors, treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity or hypercalcemia of malignancy refractory to bisphosphonates. For the prevention of skeletal-related events in patients with multiple myeloma and patients with bone metastases from solid tumors: documentation showing a trial of, intolerance to, or contraindication to zoledronic acid. For a diagnosis hypercalcemia of malignancy that is refractory to bisphosphonates: documentation of albumin-corrected calcium greater than 12.5 mg/dL. Documentation must be attached. Documentation of a trial of, intolerance to, or contraindication to IV bisphosphonates. For all diagnoses: documentation showing calcium levels were checked and will be monitored. Documentation showing calcium levels were corrected prior to therapy. Documentation showing the patient will be receiving supplementation with calcium and vitamin D. Documentation showing that an oral exam was done, and appropriate preventive dentistry was done prior to starting. Documentation showing that the patient is not pregnant or planning to become pregnant while on Xgeva if applicable. Documentation showing the patient will be using highly effective contraception during treatment and for at least 5 months after the last dose of Xgeva if applicable. RENEWALS: diagnosis of hypercalcemia of malignancy that is refractory to bisphosphonates: documentation that the corrected serum calcium is less than 11.5 mg/dL. Documentation must be attached. All diagnoses: documentation showing improvement or stabilization of disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematologist or oncologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

XIFAXAN

MEDICATION(S)
XIFAXAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Hypersensitivity to rifaximin, any of the rifamycin antimicrobial agents, or any component of the formulation.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of Traveler's Diarrhea (TD) caused by noninvasive strains of Escherichia coli, Hepatic Encephalopathy (HE), or Irritable Bowel Syndrome (IBS) with diarrhea. For TD: Documentation of inadequate response, intolerance, or contraindication to azithromycin or a fluoroquinolone (e.g., ciprofloxacin, levofloxacin). Documentation of dosing as 200 mg tablet 3 times a day. For HE: Documentation of inadequate response, intolerance, or contraindication to lactulose. Documentation of dosing as 550 mg tablet 2 times a day. For IBS with diarrhea: Documentation of inadequate response, intolerance, or contraindication to one antispasmodic agent (e.g., dicyclomine) or one anti-diarrheal agent (e.g., diphenoxylate/atropine, loperamide). Documentation of dosing as 550 mg tablet 3 times a day.

AGE RESTRICTION
12 years of age and older for TD. 18 years of age and older for IBS with diarrhea or HE.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist.

COVERAGE DURATION
TD: 3 days. HE: 12 months. IBS with diarrhea: 3 treatments (14 days per treatment) per 1 year.

OTHER CRITERIA
N/A

PART B PREREQUISITE

N/A

XOLAIR

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For moderate to severe persistent asthma: Chart notes that show patient had at least a 3 month trial of OR intolerance to oral corticosteroids and/or combination therapies (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline). Chart notes that show patient has daily asthma symptoms (coughing, wheezing, dyspnea), daily use of rescue inhalers (such as short acting beta2-agonist), asthma attacks/exacerbations two or more times per week, multiple emergency room visits within the past 12 months, or one or more nights of nocturnal asthma causing awakening. Chart notes that show patient's FEV1 is greater than 40% and less than 80% of predicted normal pre-inhaled steroids. Chart notes that show positive skin test, RAST, or in vitro reactivity to at least one perennial aeroallergen AND IgE levels between 30-700 IU/mL for patients 12 years of age and older or IgE levels between 30-1,300 IU/mL for patients between the ages of 6 to less than 12 years. For chronic spontaneous urticaria (CSU): Chart notes that show patient remained symptomatic despite H1 antihistamine treatment or has an intolerance or contraindication to H1 antihistamine treatment. For nasal polyps: Documentation of a diagnosis of nasal polyps. Documentation showing a trial of, intolerance to, or contraindication to at least one intranasal corticosteroid and at least one systemic corticosteroid. Documentation showing the patient will be treated with Xolair in combination with intranasal corticosteroids. For IgE mediated food allergy: Documentation of a diagnosis of IgE mediated food allergy. Documentation of IgE levels between 30 and 1850 IU/ml.

AGE RESTRICTION
1 year of age and older.

PRESCRIBER RESTRICTION
Pulmonologist, allergist, immunologist, dermatologist, otolaryngologist.

COVERAGE DURATION

12 months.

OTHER CRITERIA

For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

ZTALMY

MEDICATION(S)
ZTALMY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD). Applies to new starts only.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

ZURZUVAE

MEDICATION(S)
ZURZUVAE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Current pregnancy.

REQUIRED MEDICAL INFORMATION
Documentation of a diagnosis of postpartum depression. Medical records must be attached. Applies to new starts only.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a psychiatrist or obstetrician/gynecologist.

COVERAGE DURATION
30 days.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A