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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
N/A

ADALIMUMAB

MEDICATION(S)

HADLIMA, HADLIMA PUSHTOUCH, SIMLANDI (1 PEN), SIMLANDI (2 PEN), SIMLANDI (2 SYRINGE)

PENDING CMS APPROVAL

ADBRY

MEDICATION(S)

ADBRY

PENDING CMS APPROVAL

ADEMPAS

MEDICATION(S)

ADEMPAS

PENDING CMS APPROVAL

AIMOVIG

MEDICATION(S)

AIMOVIG

PENDING CMS APPROVAL

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 an anti-diarrheal agent (e.g., loperamide).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

AMBRISENTAN

MEDICATION(S)
AMBRISENTAN

PENDING CMS APPROVAL

ARCALYST

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

ARIKAYCE

MEDICATION(S)
ARIKAYCE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
MAC: Confirmation of diagnosis. 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
MAC: 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

PREREQUISITE THERAPY REQUIRED
YES

ARMODAFINIL

MEDICATION(S)

ARMODAFINIL

PENDING CMS APPROVAL

AUSTEDO

MEDICATION(S)

AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRATION 12 & 18 & 24 & 30 MG TBER THPK

PENDING CMS APPROVAL

AUVELITY

MEDICATION(S)
AUVELITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For major depressive disorder: Documentation of diagnosis. Documentation of an inadequate response, intolerance, or contraindication to at least one agent from two of the following classes: selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, atypical agents, serotonin modulators, tricyclic antidepressants. For agitation associated with dementia due to Alzheimer’s disease: 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

PREREQUISITE THERAPY REQUIRED
YES

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
N/A

PRESCRIBER RESTRICTION
SLE: Prescribed by or in consultation with a rheumatologist. LN: Prescribed by or in consultation with a nephrologist.

COVERAGE DURATION
12 months.

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

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

BESREMI

MEDICATION(S)

BESREMI, BESREMI PEN

PENDING CMS APPROVAL

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
Prescribed by or in consultation with a dermatologist, hematologist, or oncologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

BOSENTAN

MEDICATION(S)

BOSENTAN 125 MG TAB, BOSENTAN 62.5 MG TAB

PENDING CMS APPROVAL

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, temporomandibular joint disorder.

EXCLUSION CRITERIA
Cosmetic use.

REQUIRED MEDICAL INFORMATION
For all requests: Chart notes documenting diagnosis. Documentation of proposed injection site(s) and the dose that will be injected into each site. Documentation showing injections will be given no sooner than every 12 weeks. 1) For OAB: Documentation showing dose is no more than 100 units/treatment. 2) For urinary incontinence: Documentation showing dose is no more than 200 units/treatment. 3) For preventive treatment of chronic migraine: Chart notes showing the patient has chronic migraines defined as 15 or more headache days per month with at least 8 or more days being migraine days. Documentation of inadequate response, intolerance, or contraindication to at least 2 different classes of prophylactic medications (e.g., beta blockers, antidepressants, antiepileptics, verapamil) OR documentation showing inadequate response, intolerance, or contraindication to at least one CGRP inhibitor or one gepant indicated for preventative treatment of chronic migraine. Documentation showing dose is no more than 200 units/treatment. 4) For primary axillary hyperhidrosis: Documentation showing dose is no than 100 units/treatment. 5) For upper or lower limb spasticity: Documentation showing dose is no than 400 units/treatment. 6) For blepharospasm: Documentation showing dose is no more than 200 units/treatment. 7) For strabismus: Documentation showing dose is no than 25 units per muscle per treatment. 8) For sialorrhea: Documentation showing dose is no more than 100 units/treatment. 9) For cervical dystonia: Documentation showing dose is no more than 400 units/treatment. 10) For temporomandibular joint disorder: documentation showing dose is no more than 150 units/treatment.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

OAB, urinary incontinence: Prescribed by or in consultation with a urologist, urogynecologist, neurologist. Chronic migraine: Prescribed by or in consultation with a neurologist, headache specialist. Limb spasticity, cervical dystonia: Prescribed by or in consultation with a neurologist, physiatrist. Blepharospasm, strabismus: Prescribed by or in consultation with an ophthalmologist. Axillary hyperhidrosis: Prescribed by or in consultation with a dermatologist, neurologist.

COVERAGE DURATION

12 months.

OTHER CRITERIA

For reauthorization for all indications: Documentation showing the dose is consistent with total units for diagnosis (per initial request criteria). Documentation showing improvement in condition. Documentation showing repeat treatment occurring no sooner than every 12 weeks. For chronic migraine: Documentation showing a reduction in migraine frequency or severity from baseline.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

BRIVARACETAM

MEDICATION(S)
BRIVARACETAM 100 MG TAB, BRIVARACETAM 10 MG/ML SOLUTION, BRIVARACETAM 10 MG TAB, BRIVARACETAM 25 MG TAB, BRIVARACETAM 50 MG TAB, BRIVARACETAM 75 MG TAB

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

PREREQUISITE THERAPY REQUIRED
YES

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
Acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency, propionic acidemia (PA), or methylmalonic acidemia (MMA): Confirmation of diagnosis. Documentation showing use as adjunctive therapy to standard of care for treatment. Chronic hyperammonemia due to NAGS deficiency: Confirmation of diagnosis. Documentation showing use as maintenance therapy for the treatment of chronic hyperammonemia due to NAGS deficiency.

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

PREREQUISITE THERAPY REQUIRED
YES

CAYSTON

MEDICATION(S)
CAYSTON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation 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

PREREQUISITE THERAPY REQUIRED
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). 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

PREREQUISITE THERAPY REQUIRED
N/A

CLOBAZAM

MEDICATION(S)
CLOBAZAM

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

OFF LABEL USES
Dravet syndrome, treatment-refractory seizures/epilepsy.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Lennox-Gastaut syndrome (LGS): Documentation of diagnosis. Documentation of an inadequate response, intolerance, contraindication, or is concomitantly receiving one of the following: valproate, lamotrigine, rufinamide, cannabidiol (Epidiolex), felbamate. Dravet syndrome (DS): Documentation of diagnosis. Treatment refractory seizures/epilepsy: Documentation of an inadequate response, intolerance, contraindication, or is concomitantly receiving at least two other 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

PREREQUISITE THERAPY REQUIRED

YES

COSENTYX

MEDICATION(S)

COSENTYX, COSENTYX (300 MG DOSE), COSENTYX SENSOREADY (300 MG), COSENTYX SENSOREADY PEN, COSENTYX UNOREADY

PENDING CMS APPROVAL

CRESEMBA

MEDICATION(S)
CRESEMBA 186 MG CAP, CRESEMBA 74.5 MG CAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Subject to Part B vs D review for ESRD related use, if applicable. Invasive aspergillosis: Documentation of a diagnosis of invasive aspergillosis. Confirmation of one of the following: (1) Documentation of an inadequate response, intolerance, or contraindication to voriconazole (2) Documentation showing infection or disease is refractory or resistant to treatment with voriconazole. Invasive mucormycosis: Documentation of a diagnosis of invasive mucormycosis. For all other medically accepted indications: Documentation of diagnosis.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
6 months.

OTHER CRITERIA
For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

CYSTARAN

MEDICATION(S)
CYSTARAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting a diagnosis of cystinosis. Documentation showing patient has corneal cystine crystal accumulation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a nephrologist or ophthalmologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DEFERASIROX

MEDICATION(S)

DEFERASIROX 125 MG TAB SOL, DEFERASIROX 180 MG TAB, DEFERASIROX 250 MG TAB SOL, DEFERASIROX 360 MG TAB, DEFERASIROX 500 MG TAB SOL, DEFERASIROX 90 MG TAB

PENDING CMS APPROVAL

DENOSUMAB

MEDICATION(S)

BOMYNTRA 120 MG/1.7ML SOLN PRSYR, WYOST

PENDING CMS APPROVAL

DEXTROMETHORPHAN-QUINIDINE

MEDICATION(S)

DEXTROMETHORPHAN-QUINIDINE

PENDING CMS APPROVAL

DIACOMIT

MEDICATION(S)
DIACOMIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of Dravet Syndrome. Documentation of an inadequate response, intolerance, or contraindication to at least two of the following: valproic acid derivatives, topiramate, levetiracetam, fenfluramine, pharmaceutical grade cannabidiol. Documentation that Diacomit will be used in combination with clobazam. 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

PREREQUISITE THERAPY REQUIRED
YES

DIHYDROERGOTAMINE NASAL SPRAY

MEDICATION(S)

DIHYDROERGOTAMINE MESYLATE 4 MG/ML SOLUTION

PENDING CMS APPROVAL

DOPTELET

MEDICATION(S)

DOPTELET, DOPTELET SPRINKLE

PENDING CMS APPROVAL

DRIZALMA SPRINKLE

MEDICATION(S)
DRIZALMA SPRINKLE

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. Major depressive disorder (MDD): Documentation of diagnosis. Documentation of inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g., fluoxetine solution, citalopram solution, escitalopram solution, sertraline oral concentrate, paroxetine suspension). Generalized anxiety disorder (GAD): Documentation of diagnosis. Documentation of inadequate response, intolerance, or contraindication to one liquid antidepressant (e.g., escitalopram solution, paroxetine suspension). Diabetic peripheral neuropathic pain (DPNP): Documentation of diagnosis. Documentation of inadequate response, intolerance, or contraindication to gabapentin solution. Fibromyalgia (FM): Documentation of diagnosis. Documentation of inadequate response, intolerance, or contraindication to gabapentin solution. Chronic Musculoskeletal Pain (CMP) in adults: Documentation of diagnosis. Applies to new starts only.

AGE RESTRICTION
For MDD, DPNP, FM, CMP: 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

PREREQUISITE THERAPY REQUIRED

YES

DRONABINOL

MEDICATION(S)
DRONABINOL 10 MG CAP, DRONABINOL 2.5 MG CAP, DRONABINOL 5 MG CAP

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) Documented diagnosis of anorexia associated with weight loss in patients with AIDS, OR 2) 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 may need 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

PREREQUISITE THERAPY REQUIRED

YES

DROXIDOPA

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting 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

PREREQUISITE THERAPY REQUIRED
YES

DULAGLUTIDE

MEDICATION(S)
TRULICITY (0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML SOLN A-INJ)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Excluded if used for weight loss only. Concomitant use with another GLP-1 agonist containing drug or DPP4 inhibitor.

REQUIRED MEDICAL INFORMATION
Documentation such as medical records or chart notes 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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

DUPIXENT

MEDICATION(S)

DUPIXENT 200 MG/1.14ML SOLN A-INJ, DUPIXENT 200 MG/1.14ML SOLN PRSYR, DUPIXENT 300 MG/2ML SOLN A-INJ, DUPIXENT 300 MG/2ML SOLN PRSYR

PENDING CMS APPROVAL

ELTROMBOPAG

MEDICATION(S)
ELTROMBOPAG OLAMINE

PENDING CMS APPROVAL

EMGALITY

MEDICATION(S)

EMGALITY, EMGALITY (300 MG DOSE)

PENDING CMS APPROVAL

EMSAM

MEDICATION(S)
EMSAM

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 an inadequate response, intolerance, or contraindication to at least one agent from two of the following classes: selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, atypical agents, serotonin modulators, tricyclic antidepressants. 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

PREREQUISITE THERAPY REQUIRED
YES

ENBREL

MEDICATION(S)

ENBREL, ENBREL MINI, ENBREL SURECLICK

PENDING CMS APPROVAL

ENTYVIO PEN

MEDICATION(S)
ENTYVIO PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD) or a targeted synthetic DMARD.

REQUIRED MEDICAL INFORMATION
Ulcerative colitis (initial): Documentation of diagnosis with chart notes attached. One of the following (1 or 2): 1) The patient is currently maintained on Entyvio IV or is currently undergoing induction therapy (i.e., 300 mg IV at weeks 0 and 2) with Entyvio IV, OR 2) Both of the following (a and b): a) Documentation of inadequate response or intolerance to at least two of the following: an adalimumab containing agent, an infliximab containing agent, an ustekinumab containing agent, Skyrizi, Tremfya, or Rinvoq, AND b) Confirmation that patient will receive induction dosing with Entyvio IV before transitioning to subcutaneous Entyvio. Crohn's disease (initial): Documentation of diagnosis with chart notes attached. One of the following (1 or 2): 1) The patient is currently maintained on Entyvio IV or is currently undergoing induction therapy (i.e., 300 mg IV at weeks 0 and 2) with Entyvio IV, OR 2) Both of the following (a and b): a) Documentation of inadequate response or intolerance to at least two of the following: an adalimumab containing agent, an infliximab containing agent, an ustekinumab containing agent, Skyrizi, Tremfya, or Rinvoq, AND b) Confirmation that patient will receive induction dosing with Entyvio IV before transitioning to subcutaneous Entyvio.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
UC, CD: Prescribed by or in consultation with gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA

For patients new to plan with a current history of taking Entyvio Pen in the last 90 days and for reauthorization of prior approval: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

EPCLUSA

MEDICATION(S)
EPCLUSA

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

PREREQUISITE THERAPY REQUIRED

N/A

EPIDIOLEX

MEDICATION(S)
EPIDIOLEX

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), Lennox-Gastaut syndrome (LGS), or Tuberous Sclerosis Complex (TSC). Documentation showing the patient has failed to become seizure-free with at least 2 antiepileptic drugs (specify drugs tried) indicated to treat the patient's diagnosis. Confirmation that Epidiolex is being used as adjunctive therapy including documentation of antiepileptic drug(s) with which Epidiolex will be used. Request is within FDA approved labeled dosing for treatment of seizures associated with the patient's diagnosis. 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

PREREQUISITE THERAPY REQUIRED

YES

EUCRISA

MEDICATION(S)
EUCRISA

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 mild to moderate atopic dermatitis. Documentation of inadequate response, intolerance, or contraindication to at least one of the following: topical tacrolimus, topical pimecrolimus, or a prescription medium potency or higher topical steroid.

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

PREREQUISITE THERAPY REQUIRED
YES

EXXUA

MEDICATION(S)
EXXUA, EXXUA TITRATION PACK

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 an inadequate response, intolerance, or contraindication to at least one agent from two of the following classes: selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, atypical agents, serotonin modulators, tricyclic antidepressants. 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

PREREQUISITE THERAPY REQUIRED
YES

FASENRA

MEDICATION(S)

FASENRA, FASENRA PEN

PENDING CMS APPROVAL

FETZIMA

MEDICATION(S)
FETZIMA, FETZIMA TITRATION

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 an inadequate response, intolerance, or contraindication to at least one agent from two of the following classes: selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, atypical agents, serotonin modulators, tricyclic antidepressants. 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

PREREQUISITE THERAPY REQUIRED
YES

FILGRASTIM AGENTS

MEDICATION(S)

ZARXIO

PENDING CMS APPROVAL

FILSPARI

MEDICATION(S)

FILSPARI

PENDING CMS APPROVAL

FINTEPLA

MEDICATION(S)

FINTEPLA

PENDING CMS APPROVAL

GATTEX

MEDICATION(S)
GATTEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Documentation of reduction in parenteral support.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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. Confirmation that Haegarda will not be used in combination with other approved treatments for prophylaxis against 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 positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

HRM - AMITRIPTYLINE

MEDICATION(S)

AMITRIPTYLINE HCL 100 MG TAB, AMITRIPTYLINE HCL 10 MG TAB, AMITRIPTYLINE HCL 150 MG TAB, AMITRIPTYLINE HCL 25 MG TAB, AMITRIPTYLINE HCL 50 MG TAB, AMITRIPTYLINE HCL 75 MG TAB

PENDING CMS APPROVAL

HRM - AMOXAPINE

MEDICATION(S)

AMOXAPINE

PENDING CMS APPROVAL

HRM - CLOMIPRAMINE

MEDICATION(S)

CLOMIPRAMINE HCL 25 MG CAP, CLOMIPRAMINE HCL 50 MG CAP, CLOMIPRAMINE HCL 75 MG CAP, CLOMIPRAMINE HCL 25 MG CAP, CLOMIPRAMINE HCL 50 MG CAP, CLOMIPRAMINE HCL 75 MG CAP

PENDING CMS APPROVAL

HRM - CYCLOBENZAPRINE

MEDICATION(S)
CYCLOBENZAPRINE HCL 10 MG TAB, CYCLOBENZAPRINE HCL 5 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting patient's diagnosis. Chart notes documenting an explanation of the risk versus benefit profile which shows the benefit outweighs the potential risk for the use of the high-risk medication. The prescriber provides attestation of intent to monitor and address treatment-related adverse events. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, etc.) with the requested drug, the prescriber provides an explanation 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). Skeletal muscle spasms: Documentation of inadequate response, intolerance, or contraindication to at least two non-high risk formulary alternatives, such as tizanidine tablet, baclofen, dantrolene, methocarbamol 500 mg or 750 mg. Fibromyalgia: Documentation of inadequate response, intolerance, or contraindication to at least two non-high risk alternatives medically accepted for the patient’s diagnosis such as duloxetine, gabapentin, or pregabalin. Prior authorization applies to greater than cumulative 30 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: The prescriber provides an explanation that the benefit continues to outweigh the potential risk of the high-risk medication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

HRM - CYPROHEPTADINE

MEDICATION(S)

CYPROHEPTADINE HCL 4 MG TAB

PENDING CMS APPROVAL

HRM - DESIPRAMINE

MEDICATION(S)

DESIPRAMINE HCL 100 MG TAB, DESIPRAMINE HCL 10 MG TAB, DESIPRAMINE HCL 150 MG TAB, DESIPRAMINE HCL 25 MG TAB, DESIPRAMINE HCL 50 MG TAB, DESIPRAMINE HCL 75 MG TAB

PENDING CMS APPROVAL

HRM - DICYCLOMINE

MEDICATION(S)
DICYCLOMINE HCL 10 MG/5ML SOLUTION, DICYCLOMINE HCL 10 MG CAP, DICYCLOMINE HCL 20 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting patient's diagnosis. Chart notes documenting an explanation of the risk versus benefit profile which shows the benefit outweighs the potential risk for the use of the high-risk medication. The prescriber provides attestation of intent to monitor and address treatment-related adverse events. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, etc.) with the requested drug, the prescriber provides an explanation 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). Irritable bowel syndrome: Documentation of inadequate response, intolerance, or contraindication to at least one non-high risk formulary alternative, such as lubiprostone or Linzess. For an FDA approved indication not listed within criteria, no trial of alternatives is required. Prior authorization applies to greater than cumulative 30 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: The prescriber provides an explanation that the benefit continues to outweigh the potential risk of the high-risk medication.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

HRM - DIPHENOXYLATE-ATROPINE

MEDICATION(S)
DIPHENOXYLATE-ATROPINE 2.5-0.025 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting patient's diagnosis. Chart notes documenting an explanation of the risk versus benefit profile which shows the benefit outweighs the potential risk for the use of the high-risk medication. The prescriber provides attestation of intent to monitor and address treatment-related adverse events. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, etc.) with the requested drug, the prescriber provides an explanation 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). For diarrhea: Documentation of inadequate response, intolerance, or contraindication to at least one non-high risk formulary alternative, such as loperamide. For an FDA approved indication not listed within criteria, no trial of alternatives is required. Prior authorization applies to greater than cumulative 30 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: The prescriber provides an explanation that the benefit continues to outweigh the potential risk of the high-risk medication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

HRM - DOXEPIN

MEDICATION(S)

DOXEPIN HCL 100 MG CAP, DOXEPIN HCL 10 MG CAP, DOXEPIN HCL 10 MG/ML CONC, DOXEPIN HCL 150 MG CAP, DOXEPIN HCL 25 MG CAP, DOXEPIN HCL 50 MG CAP, DOXEPIN HCL 75 MG CAP

PENDING CMS APPROVAL

HRM - ESZOPICLONE

MEDICATION(S)
ESZOPICLONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis. 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. Prescriber attestation of intent to monitor and address treatment-related adverse events. For insomnia: Documentation of inadequate response, intolerance, or contraindication to at least one non-high risk formulary alternative, such as trazodone, mirtazapine, ramelteon, or doxepin 3 mg or 6 mg.

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

PREREQUISITE THERAPY REQUIRED

YES

HRM - HYDROXYZINE

MEDICATION(S)

HYDROXYZINE HCL 10 MG/5ML SYRUP, HYDROXYZINE HCL 10 MG TAB, HYDROXYZINE HCL 25 MG TAB, HYDROXYZINE HCL 50 MG/25ML SYRUP, HYDROXYZINE HCL 50 MG TAB, HYDROXYZINE PAMOATE 100 MG CAP, HYDROXYZINE PAMOATE 25 MG CAP, HYDROXYZINE PAMOATE 50 MG CAP

PENDING CMS APPROVAL

HRM - IMIPRAMINE

MEDICATION(S)

IMIPRAMINE HCL 10 MG TAB, IMIPRAMINE HCL 25 MG TAB, IMIPRAMINE HCL 50 MG TAB

PENDING CMS APPROVAL

HRM - MECLIZINE

MEDICATION(S)
MECLIZINE HCL 12.5 MG TAB, MECLIZINE HCL 25 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting patient's diagnosis. Chart notes documenting an explanation of the risk versus benefit profile which shows the benefit outweighs the potential risk for the use of the high-risk medication. The prescriber provides attestation of intent to monitor and address treatment-related adverse events. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, paroxetine, amitriptyline, dicyclomine etc.) with the requested drug, the prescriber provides an explanation 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 30 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: The prescriber provides an explanation that the benefit continues to outweigh the potential risk of the high-risk medication.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

N/A

HRM - PROMETHAZINE

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting patient's diagnosis. Chart notes documenting an explanation of the risk versus benefit profile which shows the benefit outweighs the potential risk for the use of the high-risk medication. The prescriber provides attestation of intent to monitor and address treatment-related adverse events. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine etc.) with the requested drug, the prescriber provides an explanation 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). Allergic conditions: Documentation of inadequate response, intolerance, or contraindication to at least two non-high risk alternatives such as levocetirizine, desloratadine, azelastine nasal spray, fluticasone propionate nasal spray, or mometasone nasal spray. Nausea and vomiting: Cancer diagnosis or documentation of inadequate response, intolerance, or contraindication to ondansetron or granisetron tablet. Prior authorization applies to greater than cumulative 30 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: The prescriber provides an explanation that the benefit continues to outweigh the potential risk of the high-risk medication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

HRM - TRIHEXYPHENIDYL

MEDICATION(S)
TRIHEXYPHENIDYL HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting patient's diagnosis. Chart notes documenting an explanation of the risk versus benefit profile which shows the benefit outweighs the potential risk for the use of the high-risk medication. The prescriber provides attestation of intent to monitor and address treatment-related adverse events. If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine etc.) with the requested drug, the prescriber provides an explanation 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). Extrapyramidal disease: Documentation of inadequate response, intolerance, or contraindication to at least one non-high risk formulary alternative, such as amantadine. Parkinson’s: Documentation of inadequate response, intolerance, or contraindication to at least two non-high risk formulary alternatives, such as amantadine, carbidopa/levodopa, pramipexole, or ropinirole. For an FDA-approved indication not listed within criteria, no trial of alternatives is required. Prior authorization applies to greater than cumulative 30 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: The prescriber provides an explanation that the benefit continues to outweigh the potential risk of the high-risk medication.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

HRM - ZALEPLON

MEDICATION(S)
ZALEPLON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis. 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. Prescriber attestation of intent to monitor and address treatment-related adverse events. For insomnia: Documentation of inadequate response, intolerance, or contraindication to at least one non-high risk formulary alternative, such as trazodone, mirtazapine, ramelteon, or doxepin 3 mg or 6 mg.

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

PREREQUISITE THERAPY REQUIRED

YES

HRM - ZOLPIDEM

MEDICATION(S)
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 diagnosis. 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. Prescriber attestation of intent to monitor and address treatment-related adverse events. For insomnia: Documentation of inadequate response, intolerance, or contraindication to at least one non-high risk formulary alternative, such as trazodone, mirtazapine, ramelteon, or doxepin 3 mg or 6 mg.

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

PREREQUISITE THERAPY REQUIRED

YES

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
Chart notes documenting 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: Notes showing a favorable clinical response as documented by the prescriber.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INBRIJA

MEDICATION(S)

INBRIJA

PENDING CMS APPROVAL

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: 1) Documentation of diagnosis of severe primary IGF1 deficiency confirmed by all of the following: 1) Height standard deviation score of -3.0 or less, 2) Basal IGF-1 standard deviation score of -3.0 or less, and 3) Normal or elevated growth hormone (GH). 2) 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: Confirmation of a positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

INGREZZA

MEDICATION(S)
INGREZZA

PENDING CMS APPROVAL

INTRAVENOUS IMMUNE GLOBULIN (IVIG)

MEDICATION(S)

GAMMAGARD, GAMMAGARD ERC, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PRIVIGEN

PENDING CMS APPROVAL

IVABRADINE

MEDICATION(S)
IVABRADINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic heart failure (CHF): 1) Documentation of diagnosis, 2) Documentation of stable symptomatic NYHA class II to IV heart failure, 3) Documentation of EF less than or equal to 35 percent, 4) Sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, 5) Patient has intolerance, contraindication, or is on maximally tolerated doses of beta-blockers. Chronic Heart Failure due to Dilated Cardiomyopathy: 1) Documentation of diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (CHF-DC), 2) 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: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

KALYDECO

MEDICATION(S)

KALYDECO

PENDING CMS APPROVAL

KERENDIA

MEDICATION(S)

KERENDIA

PENDING CMS APPROVAL

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
Chart notes documenting diagnosis. Documentation showing inadequate response, contraindication, or intolerance to two different agents used to treat multiple sclerosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For patients new to plan with a current history of taking Kesimpta in the last 90 days and for reauthorization of prior approval: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
One of the following: 1) Documented diagnosis of acromegaly. Labs documenting 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. Documentation of an inadequate response, intolerance or contraindication to surgery or radiation therapy OR there is a clinical reason why the patient has not had surgery or radiation therapy. 2) Documented diagnosis of unresectable, well or moderately differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors. 3) 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: confirmation of a positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

LEQEMBI IQLIK

MEDICATION(S)

LEQEMBI IQLIK, LEQEMBI IQLIK (500 MG DOSE)

PENDING CMS APPROVAL

LEUKINE

MEDICATION(S)
LEUKINE

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

OFF LABEL USES
Neuroblastoma

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Subject to Part B vs D review. Documentation of diagnosis. For the treatment of high-risk neuroblastoma, confirmation that Leukine is being used in combination with a regimen containing a GD2-binding monoclonal antibody (i.e., naxitamab, dinutuximab).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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
Chart notes documenting diagnosis of sickle cell disease. Documentation that the request is to reduce acute complications of sickle cell disease. Documentation of inadequate response, intolerance, or contraindication to hydroxyurea OR documentation showing L-glutamine will be used in combination with hydroxyurea. Request is within the FDA labeled dose.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

LIDOCAINE PATCHES

MEDICATION(S)
LIDOCAINE 5 % PATCH

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes documenting a 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

PREREQUISITE THERAPY REQUIRED
N/A

LIVTENCITY

MEDICATION(S)

LIVTENCITY

PENDING CMS APPROVAL

LYBALVI

MEDICATION(S)
LYBALVI

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 schizophrenia or bipolar I disorder. One of the following: 1) therapeutic failure, intolerance or contraindication to two generic atypical antipsychotics OR 2) currently stable and responding to olanzapine but experiencing weight gain from the medication. 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

PREREQUISITE THERAPY REQUIRED
YES

MACITENTAN

MEDICATION(S)

MACITENTAN

PENDING CMS APPROVAL

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 acute or chronic Hepatitis C (CHC) without cirrhosis or with compensated cirrhosis. 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

PREREQUISITE THERAPY REQUIRED

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 one 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

PREREQUISITE THERAPY REQUIRED
YES

MIFEPRISTONE

MEDICATION(S)
MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

MODAFINIL

MEDICATION(S)

MODAFINIL 100 MG TAB, MODAFINIL 200 MG TAB

PENDING CMS APPROVAL

NAYZILAM

MEDICATION(S)
NAYZILAM

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
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

PREREQUISITE THERAPY REQUIRED
N/A

NEMLUVIO

MEDICATION(S)
NEMLUVIO

PENDING CMS APPROVAL

NEXLETOL

MEDICATION(S)
NEXLETOL

PENDING CMS APPROVAL

NEXLIZET

MEDICATION(S)

NEXLIZET

PENDING CMS APPROVAL

NINTEDANIB

MEDICATION(S)

NINTEDANIB ESYLATE, OFEV

PENDING CMS APPROVAL

NUCALA

MEDICATION(S)

NUCALA

PENDING CMS APPROVAL

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. 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

PREREQUISITE THERAPY REQUIRED
N/A

NURTEC

MEDICATION(S)

NURTEC

PENDING CMS APPROVAL

OCTREOTIDE

MEDICATION(S)

OCTREOTIDE ACETATE 1000 MCG/ML SOLUTION, OCTREOTIDE ACETATE 100 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 100 MCG/ML SOLUTION, OCTREOTIDE ACETATE 200 MCG/ML SOLUTION, OCTREOTIDE ACETATE 500 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 500 MCG/ML SOLUTION, OCTREOTIDE ACETATE 50 MCG/ML SOLN PRSYR, OCTREOTIDE ACETATE 50 MCG/ML SOLUTION

PENDING CMS APPROVAL

OMNITROPE

MEDICATION(S)
OMNITROPE

PENDING CMS APPROVAL

OPIPZA

MEDICATION(S)

OPIPZA

PENDING CMS APPROVAL

ORAL ONCOLOGY - ABIRATERONE ACETATE

MEDICATION(S)
ABIRATERONE ACETATE, ABIRTEGA, YONSA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - AKEEGA

MEDICATION(S)
AKEEGA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ALECENSA

MEDICATION(S)
ALECENSA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ALUNBRIG

MEDICATION(S)
ALUNBRIG

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - AUGTYRO

MEDICATION(S)
AUGTYRO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - AVMAPKI FAKZYNJA CO-PACK

MEDICATION(S)
AVMAPKI FAKZYNJA CO-PACK

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - AYVAKIT

MEDICATION(S)
AYVAKIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation 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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - BALVERSA

MEDICATION(S)
BALVERSA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - BEXAROTENE

MEDICATION(S)
BEXAROTENE 75 MG CAP

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - BOSULIF

MEDICATION(S)
BOSULIF 100 MG CAP, BOSULIF 100 MG TAB, BOSULIF 500 MG TAB, BOSULIF 50 MG CAP, BOSUTINIB 400 MG TAB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - BRAFTOVI

MEDICATION(S)
BRAFTOVI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - BRUKINSA

MEDICATION(S)
BRUKINSA 160 MG TAB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - CABOMETYX

MEDICATION(S)
CABOMETYX

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - CALQUENCE

MEDICATION(S)
CALQUENCE 100 MG TAB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - CAPRELSA

MEDICATION(S)
CAPRELSA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - COMETRIQ

MEDICATION(S)
COMETRIQ (100 MG DAILY DOSE), COMETRIQ (140 MG DAILY DOSE), COMETRIQ (60 MG DAILY DOSE)

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - COPIKTRA

MEDICATION(S)
COPIKTRA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - COTELLIC

MEDICATION(S)
COTELLIC

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - DASATINIB

MEDICATION(S)
DASATINIB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - DAURISMO

MEDICATION(S)
DAURISMO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ENSACOVE

MEDICATION(S)
ENSACOVE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ERIVEDGE

MEDICATION(S)
ERIVEDGE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ERLEADA

MEDICATION(S)
ERLEADA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ERLOTINIB

MEDICATION(S)
ERLOTINIB HCL

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - EULEXIN

MEDICATION(S)
EULEXIN

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - EVEROLIMUS

MEDICATION(S)
EVEROLIMUS 10 MG TAB, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 2 MG TAB SOL, EVEROLIMUS 3 MG TAB SOL, EVEROLIMUS 5 MG TAB, EVEROLIMUS 5 MG TAB SOL, EVEROLIMUS 7.5 MG TAB, TORPENZ, YULITHIRA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - FOTIVDA

MEDICATION(S)
FOTIVDA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - FRUZAQLA

MEDICATION(S)
FRUZAQLA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - GAVRETO

MEDICATION(S)
GAVRETO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - GEFITINIB

MEDICATION(S)
GEFITINIB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - GILOTRIF

MEDICATION(S)
GILOTRIF

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - GOMEKLI

MEDICATION(S)
GOMEKLI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - HERNEXEOS

MEDICATION(S)
HERNEXEOS

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - HYRNUO

MEDICATION(S)
HYRNUO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - IBRANCE

MEDICATION(S)
IBRANCE 100 MG TAB, IBRANCE 125 MG CAP, IBRANCE 125 MG TAB, IBRANCE 75 MG TAB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - IBTROZI

MEDICATION(S)
IBTROZI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ICLUSIG

MEDICATION(S)
ICLUSIG

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - IDHIFA

MEDICATION(S)
IDHIFA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - IMATINIB

MEDICATION(S)
IMATINIB MESYLATE 100 MG TAB, IMATINIB MESYLATE 400 MG TAB, IMKELDI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - IMBRUVICA

MEDICATION(S)
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

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - INLURIYO

MEDICATION(S)
INLURIYO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - INLYTA

MEDICATION(S)
INLYTA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - INQOVI

MEDICATION(S)
INQOVI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - INREBIC

MEDICATION(S)
INREBIC

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ITOVEBI

MEDICATION(S)
ITOVEBI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - IWILFIN

MEDICATION(S)
IWILFIN

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - JAKAFI

MEDICATION(S)
JAKAFI, JAKAFI XR

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - JAYPIRCA

MEDICATION(S)
JAYPIRCA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - JIDEYTRO

MEDICATION(S)

JIDEYTRO

PENDING CMS APPROVAL

ORAL ONCOLOGY - KISQALI

MEDICATION(S)
KISQALI (200 MG DOSE), KISQALI (400 MG DOSE), KISQALI (600 MG DOSE)

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - KOMZIFTI

MEDICATION(S)
KOMZIFTI

PA INDICATION INDICATOR
1 - All FDA-Approved 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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - KOSELUGO

MEDICATION(S)
KOSELUGO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - KRAZATI

MEDICATION(S)
KRAZATI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LAPATINIB DITOSYLATE

MEDICATION(S)
LAPATINIB DITOSYLATE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LAZCLUZE

MEDICATION(S)
LAZCLUZE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LENALIDOMIDE

MEDICATION(S)
LENALIDOMIDE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LENVIMA

MEDICATION(S)
LENVIMA (10 MG DAILY DOSE), LENVIMA (12 MG DAILY DOSE), LENVIMA (14 MG DAILY DOSE), LENVIMA (18 MG DAILY DOSE), LENVIMA (20 MG DAILY DOSE), LENVIMA (24 MG DAILY DOSE), LENVIMA (4 MG DAILY DOSE), LENVIMA (8 MG DAILY DOSE)

PA 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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LIFYORLI

MEDICATION(S)
LIFYORLI (125 MG DOSE), LIFYORLI (150 MG DOSE)

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LOMUSTINE

MEDICATION(S)
LOMUSTINE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LONSURF

MEDICATION(S)
LONSURF

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LORBRENA

MEDICATION(S)
LORBRENA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LUMAKRAS

MEDICATION(S)
LUMAKRAS

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LYNPARZA

MEDICATION(S)
LYNPARZA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - LYTGOBI

MEDICATION(S)
LYTGOBI (12 MG DAILY DOSE), LYTGOBI (16 MG DAILY DOSE), LYTGOBI (20 MG DAILY DOSE)

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - MEKINIST

MEDICATION(S)
MEKINIST

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - MEKTOVI

MEDICATION(S)
MEKTOVI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - MODEYSO

MEDICATION(S)
MODEYSO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - NERLYNX

MEDICATION(S)
NERLYNX

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - NILOTINIB

MEDICATION(S)
DANZITEN, NILOTINIB D-TARTRATE, NILOTINIB HCL

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - NINLARO

MEDICATION(S)
NINLARO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - NUBEQA

MEDICATION(S)
NUBEQA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ODOMZO

MEDICATION(S)
ODOMZO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - OGSIVEO

MEDICATION(S)
OGSIVEO 100 MG TAB, OGSIVEO 150 MG TAB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - OJEMDA

MEDICATION(S)
OJEMDA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - OJJAARA

MEDICATION(S)
OJJAARA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ONUREG

MEDICATION(S)
ONUREG

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ORGOVYX

MEDICATION(S)
ORGOVYX

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ORSERDU

MEDICATION(S)
ORSERDU

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - PAZOPANIB

MEDICATION(S)
PAZOPANIB HCL 200 MG TAB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - PEMAZYRE

MEDICATION(S)
PEMAZYRE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - PIQRAY

MEDICATION(S)
PIQRAY (200 MG DAILY DOSE), PIQRAY (250 MG DAILY DOSE), PIQRAY (300 MG DAILY DOSE)

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - POMALIDOMIDE

MEDICATION(S)
POMALIDOMIDE, POMALYST

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - QINLOCK

MEDICATION(S)
QINLOCK

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - RETEVMO

MEDICATION(S)
RETEVMO 120 MG TAB, RETEVMO 160 MG TAB, RETEVMO 40 MG TAB, RETEVMO 80 MG TAB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - REVUFORJ

MEDICATION(S)
REVUFORJ

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - REZLIDHIA

MEDICATION(S)
REZLIDHIA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ROMVIMZA

MEDICATION(S)
ROMVIMZA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ROZLYTREK

MEDICATION(S)
ROZLYTREK

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - RUBRACA

MEDICATION(S)
RUBRACA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - RYDAPT

MEDICATION(S)
RYDAPT

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - SCEMBLIX

MEDICATION(S)
SCEMBLIX

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - SORAFENIB TOSYLATE

MEDICATION(S)
SORAFENIB TOSYLATE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - STIVARGA

MEDICATION(S)
STIVARGA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - SUNITINIB MALATE

MEDICATION(S)
SUNITINIB MALATE

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TABRECTA

MEDICATION(S)
TABRECTA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TAFINLAR

MEDICATION(S)
TAFINLAR

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TAGRISSO

MEDICATION(S)
TAGRISSO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TALZENNA

MEDICATION(S)
TALZENNA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TEPMETKO

MEDICATION(S)
TEPMETKO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - THALOMID

MEDICATION(S)
THALOMID 100 MG CAP, THALOMID 50 MG CAP

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TIBSOVO

MEDICATION(S)
TIBSOVO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TRUQAP

MEDICATION(S)
TRUQAP

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TUKYSA

MEDICATION(S)
TUKYSA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - TURALIO

MEDICATION(S)
TURALIO 125 MG CAP

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - VANFLYTA

MEDICATION(S)
VANFLYTA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - VENCLEXTA

MEDICATION(S)
VENCLEXTA, VENCLEXTA STARTING PACK

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - VERZENIO

MEDICATION(S)
VERZENIO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - VITRAKVI

MEDICATION(S)
VITRAKVI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - VONJO

MEDICATION(S)
VONJO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - VORANIGO

MEDICATION(S)
VORANIGO

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - WELIREG

MEDICATION(S)
WELIREG

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - XALKORI

MEDICATION(S)
XALKORI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - XOSPATA

MEDICATION(S)
XOSPATA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - XPOVIO

MEDICATION(S)
XPOVIO (100 MG ONCE WEEKLY), XPOVIO (40 MG ONCE WEEKLY) 10 MG TAB THPK, XPOVIO (40 MG TWICE WEEKLY), XPOVIO (60 MG ONCE WEEKLY), XPOVIO (60 MG TWICE WEEKLY), XPOVIO (80 MG ONCE WEEKLY), XPOVIO (80 MG TWICE WEEKLY)

PA 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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - XTANDI

MEDICATION(S)
XTANDI

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ZEJULA

MEDICATION(S)
ZEJULA 100 MG TAB, ZEJULA 200 MG TAB, ZEJULA 300 MG TAB

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ZELBORAF

MEDICATION(S)
ZELBORAF

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ZENBEXUS

MEDICATION(S)

ZENBEXUS

PENDING CMS APPROVAL

ORAL ONCOLOGY - ZOLINZA

MEDICATION(S)
ZOLINZA

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

PREREQUISITE THERAPY REQUIRED
N/A

ORAL ONCOLOGY - ZYKADIA

MEDICATION(S)
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

PREREQUISITE THERAPY REQUIRED
N/A

ORKAMBI

MEDICATION(S)

ORKAMBI

PENDING CMS APPROVAL

OTEZLA

MEDICATION(S)

OTEZLA, OTEZLA/OTEZLA XR INITIATION PK, OTEZLA XR

PENDING CMS APPROVAL

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
Prescribed by or in consultation with a dermatologist or oncologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PART D INSULIN SUPPLIES

MEDICATION(S)
BD ALCOHOL PADS, GAUZE PADS & DRESSINGS - PADS 2 X 2, INSULIN PEN NEEDLE (NOVO/BD/EMBECTA/ULTIMED/TRIVIDIA), INSULIN SYRINGE (DISP) U-100 0.3 ML (BD/EMBECTA/ULTIMED/ALLISON/TRIVIDIA/MHC), INSULIN SYRINGE (DISP) U-100 1/2 ML (BD/EMBECTA/ULTIMED/ALLISON/TRIVIDIA/MHC), INSULIN SYRINGE (DISP) U-100 1 ML (BD/EMBECTA/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

PREREQUISITE THERAPY REQUIRED

YES

MEDICATION(S)

ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, 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, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, AMINOSYN II, AMINOSYN-PF, AMPHOTERICIN B 50 MG RECON SOLN, AMPHOTERICIN B LIPOSOME, APREPITANT, ARFORMOTEROL TARTRATE, AVASTIN, AZACITIDINE, AZATHIOPRINE 50 MG TAB, BORTEZOMIB 3.5 MG RECON SOLN, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, 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 50 MG TAB, CYCLOPHOSPHAMIDE (25 MG CAP, 50 MG CAP), CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE MODIFIED, 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 500 MG/10ML SOLUTION, FLUOROURACIL 5 GM/100ML SOLUTION, FORMOTEROL FUMARATE 20 MCG/2ML NEBU SOLN, FULVESTRANT, GENGRAF, GRANISETRON HCL 1 MG TAB, HEPLISAV-B, HERCEPTIN HYLECTA, IMOVAX RABIES, INFLECTRA, INTRALIPID, IPRATROPIUM-ALBUTEROL, IPRATROPIUM BROMIDE 0.02 % SOLUTION, JYNNEOS, KADCYLA, KANJINTI, KEYTRUDA, LEUPROLIDE ACETATE 1 MG/0.2ML KIT, 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), MVASI, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NULOJIX, NUTRILIPID, OGIVRI, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, ONDANSETRON HCL ORAL SOLN 4 MG/5ML, PENTAMIDINE ISETHIONATE, PENTAMIDINE ISETHIONATE FOR NEBULIZATION SOLN 300 MG, PLENAMINE, PREMASOL, PROCRIT, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PROSOL, PULMOZYME, RABAVERT, RECOMBIVAX HB, RENFLEXIS, RETACRIT, RUXIENCE, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 1 MG TAB, 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, NYVEPRIA

PENDING CMS APPROVAL

PERAMPANEL

MEDICATION(S)
PERAMPANEL

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

PREREQUISITE THERAPY REQUIRED
YES

PHOSPHATE BINDERS - CALCIUM ACETATE

MEDICATION(S)
CALCIUM ACETATE (PHOS BINDER)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients on dialysis.

REQUIRED MEDICAL INFORMATION
Subject to Part B vs D review. Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PHOSPHATE BINDERS - SEVELAMER

MEDICATION(S)
SEVELAMER CARBONATE 800 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patients on dialysis.

REQUIRED MEDICAL INFORMATION
Subject to Part B vs D review. Documentation of diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

PIRFENIDONE

MEDICATION(S)
PIRFENIDONE

PENDING CMS APPROVAL

POLYPHARMACY - ALPRAZOLAM

MEDICATION(S)

ALPRAZOLAM 0.25 MG TAB, ALPRAZOLAM 0.5 MG TAB, ALPRAZOLAM 1 MG TAB, ALPRAZOLAM 2 MG TAB

PENDING CMS APPROVAL

POLYPHARMACY - DIAZEPAM

MEDICATION(S)
DIAZEPAM 10 MG TAB, DIAZEPAM 2 MG TAB, DIAZEPAM 5 MG/5ML SOLUTION, DIAZEPAM 5 MG/ML CONC, DIAZEPAM 5 MG TAB, DIAZEPAM INTENSOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Patient has an FDA labeled contraindication to the requested drug.

REQUIRED MEDICAL INFORMATION
Prior authorization does not apply to patients receiving hospice care, palliative care, diagnosed with cancer or sickle-cell disease, or patients receiving cancer-related pain treatment. Chart notes documenting patient's diagnosis. Chart notes documenting an explanation of the risk versus benefit profile which shows the benefit outweighs the potential risk for the use of the high-risk medication with concurrent opioid therapy. The prescriber provides attestation of intent to monitor and address treatment-related adverse events. For anxiety disorder: The requested drug is being used concurrently with buspirone, a selective serotonin reuptake inhibitor (SSRI), or serotonin-norepinephrine reuptake inhibitor (SNRI) until buspirone, the SSRI, or SNRI becomes effective for the symptoms of anxiety OR documentation of inadequate response, intolerance, or contraindication to buspirone and at least one agent from each the following classes: SSRIs and SNRIs. For skeletal muscle spasms: Documentation of inadequate response, intolerance, or contraindication to at least two non-high risk formulary alternatives, such as tizanidine tablet, baclofen, dantrolene, methocarbamol 500 mg or 750 mg. For an FDA-approved indication not listed within criteria, no trial of alternatives is required. Prior authorization applies when greater than or equal to a 15-day supply of diazepam is filled with concurrent opioid use. Applies to new starts only.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: The prescriber provides an explanation that the benefit continues to outweigh the potential risk of the high-risk medication with concurrent opioid therapy.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

POLYPHARMACY - LORAZEPAM

MEDICATION(S)

LORAZEPAM 0.5 MG TAB, LORAZEPAM 1 MG TAB, LORAZEPAM 2 MG/ML CONC, LORAZEPAM 2 MG TAB, LORAZEPAM INTENSOL

PENDING CMS APPROVAL

POLYPHARMACY - TEMAZEPAM

MEDICATION(S)

TEMAZEPAM 15 MG CAP, TEMAZEPAM 30 MG CAP

PENDING CMS APPROVAL

POSACONAZOLE

MEDICATION(S)
POSACONAZOLE 100 MG TAB DR

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

PREREQUISITE THERAPY REQUIRED
N/A

PRETOMANID

MEDICATION(S)

PRETOMANID

PENDING CMS APPROVAL

PREVYMIS

MEDICATION(S)
PREVYMIS 120 MG PACKET, PREVYMIS 20 MG PACKET, 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

PREREQUISITE THERAPY REQUIRED
N/A

PROLASTIN-C

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.

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

PREREQUISITE THERAPY REQUIRED

N/A

PYRIMETHAMINE

MEDICATION(S)

PYRIMETHAMINE 25 MG TAB

PENDING CMS APPROVAL

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: 1) Documentation of diagnosis of uncomplicated Plasmodium falciparum malaria with confirmation of chloroquine resistance. Or, 2) 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

PREREQUISITE THERAPY REQUIRED
YES

QULIPTA

MEDICATION(S)
QULIPTA

PENDING CMS APPROVAL

RALDESY

MEDICATION(S)

RALDESY

PENDING CMS APPROVAL

REPATHA

MEDICATION(S)
REPATHA, 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

PREREQUISITE THERAPY REQUIRED
N/A

REVCOVI

MEDICATION(S)
REVCOVI

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 D review. Documentation of diagnosis. One of the following: 1) Documentation of absent or very low adenosine deaminase activity in red blood cells (less than 1 percent of normal), OR 2) Molecular genetic testing confirming diagnosis. Documentation of severely impaired immune function (e.g., lymphopenia, extensive dermatitis, persistent diarrhea, recurrent pneumonia, life threatening illness caused by opportunistic infections). Documentation showing the patient has failed or is not a candidate for hematopoietic cell transplantation (HCT).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an immunologist, hematologist, oncologist, or specialist in inherited metabolic disorders.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization: Documentation showing stabilization or improvement in immune status (such as infection rate, incidence and duration of hospitalization, performance status).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

N/A

REXULTI

MEDICATION(S)
REXULTI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For agitation associated with dementia due to Alzheimer’s disease: Documentation of diagnosis. For major depressive disorder: Documentation of diagnosis. Documentation showing the requested drug will be used as adjunctive therapy to antidepressants. Documentation of an inadequate response, intolerance, or contraindication to two formulary generic atypical antipsychotics. For schizophrenia: Documentation of diagnosis. Documentation of an inadequate response, intolerance, or contraindication to two formulary generic atypical antipsychotics. 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

PREREQUISITE THERAPY REQUIRED

YES

REZDIFFRA

MEDICATION(S)

REZDIFFRA

PENDING CMS APPROVAL

REZUROCK

MEDICATION(S)
REZUROCK

PENDING CMS APPROVAL

RINVOQ

MEDICATION(S)
RINVOQ, RINVOQ LQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD), a targeted synthetic DMARD, JAK inhibitors, or with potent immunosuppressants such as azathioprine and cyclosporine.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis with chart notes attached. For rheumatoid arthritis (RA), psoriatic arthritis (PsA), active ankylosing spondylitis (AS), active non-radiographic axial spondyloarthritis (nr-axSpA), or polyarticular juvenile idiopathic arthritis (pJIA): Documentation of inadequate response, intolerance, or contraindication to at least one TNF blocker. For moderately to severely active ulcerative colitis (UC) or moderately to severely active Crohn’s disease (CD): one of the following (1) documentation of inadequate response or intolerance to at least one TNF blocker, (2) documentation of inadequate response or intolerance to at least one approved systemic therapy if TNF blockers are not clinically appropriate, OR contraindication to both TNF blockers and approved systemic therapies consistent with current clinical treatment guidelines. For atopic dermatitis (AD): Documentation of inadequate response, intolerance, or contraindication to at least one other systemic drug (including biologics) used to treat refractory, moderate to severe AD. For giant cell arteritis (GCA): Documentation that the patient has tried or is currently taking a systemic corticosteroid or corticosteroids are contraindicated.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA/AS/nr-axSpA/pJIA/GCA: prescribed by or in consultation with a rheumatologist. PsA: prescribed by or in consultation with a rheumatologist or dermatologist. AD: prescribed by or in consultation with an allergist, immunologist or dermatologist. UC/CD: prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For patients new to plan with a current history of taking Rinvoq in the last 90 days and for reauthorization of prior approval: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
YES

SAPROPTERIN

MEDICATION(S)
JAVYGTOR, SAPROPTERIN DIHYDROCHLORIDE, ZELVYSIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of phenylketonuria confirmed by blood phenylalanine concentrations with labs attached.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
For reauthorization: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

SEMAGLUTIDE

MEDICATION(S)
OZEMPIC, OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN, OZEMPIC (1 MG/DOSE), OZEMPIC (2 MG/DOSE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Excluded if used for weight loss only. Concomitant use with another GLP-1 agonist containing drug or DPP4 inhibitor.

REQUIRED MEDICAL INFORMATION
Documentation such as medical records or chart notes 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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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

PREREQUISITE THERAPY REQUIRED
N/A

SILDENAFIL

MEDICATION(S)

SILDENAFIL CITRATE 20 MG TAB

PENDING CMS APPROVAL

SIRTURO

MEDICATION(S)
SIRTURO

PENDING CMS APPROVAL

SKYRIZI

MEDICATION(S)
SKYRIZI, SKYRIZI PEN

PENDING CMS APPROVAL

SODIUM OXYBATE

MEDICATION(S)

SODIUM OXYBATE

PENDING CMS APPROVAL

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

PREREQUISITE THERAPY REQUIRED
N/A

SOMAVERT

MEDICATION(S)

SOMAVERT

PENDING CMS APPROVAL

SYMPAZAN

MEDICATION(S)
SYMPAZAN

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

OFF LABEL USES
Dravet syndrome, treatment-refractory seizures/epilepsy.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Lennox-Gastaut syndrome (LGS): Documentation of diagnosis. Documentation of an inadequate response, intolerance, contraindication, or is concomitantly receiving one of the following: valproate, lamotrigine, rufinamide, cannabidiol (Epidiolex), felbamate. Dravet syndrome (DS): Documentation of diagnosis. Treatment refractory seizures/epilepsy: Documentation of an inadequate response, intolerance, contraindication, or is concomitantly receiving at least two other antiepileptics such as: felbamate, lamotrigine, levetiracetam, topiramate, valproate, zonisamide. For all diagnoses: Must have clinical documentation as to why clobazam tablet and generic clobazam suspension cannot be used. 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

PREREQUISITE THERAPY REQUIRED

YES

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
Chart notes documenting diagnosis of benign prostatic hyperplasia (BPH). Documentation of inadequate response, intolerance, or contraindication to at least one alpha blocker AND documentation of inadequate response, intolerance, or contraindication to at least one 5-alpha-reductase inhibitor.

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

PREREQUISITE THERAPY REQUIRED
YES

TADALAFIL PAH

MEDICATION(S)

ALYQ, TADALAFIL (PAH)

PENDING CMS APPROVAL

TARPEYO

MEDICATION(S)
TARPEYO

PENDING CMS APPROVAL

TASIMELTEON

MEDICATION(S)

TASIMELTEON

PENDING CMS APPROVAL

TAVNEOS

MEDICATION(S)
TAVNEOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Initial: 6 months. Reauthorization: 12 months.

OTHER CRITERIA
For reauthorization: Confirmation of disease stability or improvement. Confirmation showing the patient will continue to take in combination with standard therapy (e.g., rituximab, cyclophosphamide, mycophenolate, azathioprine, and/or glucocorticoids).

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

TERIPARATIDE

MEDICATION(S)

BONSITY, TERIPARATIDE

PENDING CMS APPROVAL

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 CYPIONATE 100 MG/ML SOLUTION, TESTOSTERONE CYPIONATE 200 MG/ML SOLUTION, TESTOSTERONE ENANTHATE 200 MG/ML SOLUTION, TESTOSTERONE TD GEL PUMP 20.25 MG/ACT (1.62%)

PENDING CMS APPROVAL

TETRABENAZINE

MEDICATION(S)
TETRABENAZINE

PENDING CMS APPROVAL

TIRZEPATIDE

MEDICATION(S)
MOUNJARO (2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML, 10MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML SOLN A-INJ)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Excluded if used for weight loss only. Concomitant use with another GLP-1 agonist containing drug or DPP4 inhibitor.

REQUIRED MEDICAL INFORMATION
Documentation such as medical records or chart notes 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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOBI PODHALER

MEDICATION(S)
TOBI PODHALER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cystic fibrosis (CF): 1) Diagnosis of cystic fibrosis AND 2) Evidence of Pseudomonas aeruginosa in the lungs.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CF: Prescribed by or in consultation with a pulmonologist, infectious disease specialist, or specialist affiliated with a CF care center.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
N/A

TOCILIZUMAB

MEDICATION(S)

TYENNE

PENDING CMS APPROVAL

TOFACITINIB

MEDICATION(S)
TOFACITINIB CITRATE 10 MG TAB, TOFACITINIB CITRATE 1 MG/ML SOLUTION, TOFACITINIB CITRATE 5 MG TAB, TOFACITINIB CITRATE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD), a targeted synthetic DMARD, or with potent immunosuppressants such as azathioprine and cyclosporine.

REQUIRED MEDICAL INFORMATION
Chart notes documenting diagnosis. For all diagnoses: documentation of an inadequate response or intolerance to at least one TNF blocker indicated to treat the diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an appropriate specialist such as a rheumatologist or gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For patients new to plan with a current history of taking tofacitinib in the last 90 days and for reauthorization of prior approval: confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

TOLVAPTAN (JYNARQUE)

MEDICATION(S)

TOLVAPTAN 15 MG TAB (GENERIC JYNARQUE), TOLVAPTAN (15 MG TAB THPK, 30 & 15 MG TAB THPK, 45 & 15 MG TAB THPK, 60 & 30 MG TAB THPK, 90 & 30 MG TAB THPK – GENERIC JYNARQUE), TOLVAPTAN 30 MG TAB (GENERIC JYNARQUE)

PENDING CMS APPROVAL

TOPICAL RETINOIDS - TAZAROTENE

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

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Cosmetic use.

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

PREREQUISITE THERAPY REQUIRED
N/A

TOPICAL RETINOIDS - TRETINOIN

MEDICATION(S)
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
Cosmetic use.

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

PREREQUISITE THERAPY REQUIRED
N/A

TREMFYA

MEDICATION(S)
TREMFYA, TREMFYA-CD/UC INDUCTION, TREMFYA ONE-PRESS, TREMFYA PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD) or a targeted synthetic DMARD.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis with chart notes attached. For moderate to severe plaque psoriasis (PsO): Documentation that the patient is a candidate for systemic therapy or phototherapy. Documentation of inadequate response, intolerance, or contraindication to at least one of the following: methotrexate, UVB therapy, or acitretin OR the patient had a 3-month trial of a biologic or targeted synthetic DMARD for the requested indication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PsO: Prescribed by or in consultation with a dermatologist. PsA: Prescribed by or in consultation with dermatologist or rheumatologist. UC, CD: Prescribed by or in consultation with gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For patients new to plan with a current history of taking Tremfya in the last 90 days and for reauthorization of prior approval: Confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED

YES

TRIKAFTA

MEDICATION(S)

TRIKAFTA

PENDING CMS APPROVAL

TRINTELLIX

MEDICATION(S)
TRINTELLIX

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 an inadequate response, intolerance, or contraindication to at least one agent from two of the following classes: selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, atypical agents, serotonin modulators, tricyclic antidepressants. 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

PREREQUISITE THERAPY REQUIRED
YES

TYMLOS

MEDICATION(S)

TYMLOS

PENDING CMS APPROVAL

UBRELVY

MEDICATION(S)
UBRELVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
Concomitant use with another CGRP antagonist or gepant for the same indication.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis with chart notes attached. For acute treatment of migraine: Documentation of inadequate response, intolerance, or contraindication to at least 1 triptan.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
For reauthorization for acute treatment of migraine: confirmation of positive clinical response.

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PENDING CMS APPROVAL

USTEKINUMAB

MEDICATION(S)

OTULFI, PYZCHIVA 130 MG/26ML SOLUTION, PYZCHIVA 45 MG/0.5ML SOLN PRSYR, PYZCHIVA 45 MG/0.5ML SOLUTION, PYZCHIVA 90 MG/ML SOLN PRSYR, YESINTEK

PENDING CMS APPROVAL

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

PREREQUISITE THERAPY REQUIRED
YES

VALTOCO

MEDICATION(S)
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
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

PREREQUISITE THERAPY REQUIRED
N/A

VERQUVO

MEDICATION(S)
VERQUVO

PENDING CMS APPROVAL

VIGABATRIN

MEDICATION(S)
VIGABATRIN, VIGADRONE

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. 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

PREREQUISITE THERAPY REQUIRED
YES

VOQUEZNA DUAL PAK

MEDICATION(S)
VOQUEZNA DUAL PAK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Helicobacter pylori: All of the following: 1) Documentation of diagnosis, and 2) An inadequate response, intolerance, or contraindication to at least ONE of the following: a) Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]), OR b) Clarithromycin based therapy (e.g., clarithromycin and amoxicillin/metronidazole and proton pump inhibitor [PPI]).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 treatment (14 days) in 30 days.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

VOQUEZNA TRIPLE PAK

MEDICATION(S)
VOQUEZNA TRIPLE PAK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Helicobacter pylori: All of the following: 1) Documentation of diagnosis, and 2) An inadequate response, intolerance, or contraindication to at least ONE of the following: a) Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]), OR b) Clarithromycin based therapy (e.g., clarithromycin and amoxicillin/metronidazole and proton pump inhibitor [PPI]).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 treatment (14 days) in 30 days.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
YES

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

PREREQUISITE THERAPY REQUIRED
N/A

VOSEVI

MEDICATION(S)

VOSEVI

PENDING CMS APPROVAL

VOWST

MEDICATION(S)
VOWST

PENDING CMS APPROVAL

VYNDAMAX

MEDICATION(S)

VYNDAMAX

PENDING CMS APPROVAL

WEGOVY INJECTION

MEDICATION(S)

WEGOVY 0.25 MG/0.5ML SOLN A-INJ, WEGOVY 0.5 MG/0.5ML SOLN A-INJ, WEGOVY 1.7 MG/0.75ML SOLN A-INJ, WEGOVY 1 MG/0.5ML SOLN A-INJ, WEGOVY 2.4 MG/0.75ML SOLN A-INJ

PENDING CMS APPROVAL

WEGOVY TABLET

MEDICATION(S)

WEGOVY 1.5 MG TAB, WEGOVY 25 MG TAB, WEGOVY 4 MG TAB, WEGOVY 9 MG TAB

PENDING CMS APPROVAL

WINREVAIR

MEDICATION(S)
WINREVAIR

PENDING CMS APPROVAL

XCOPRI

MEDICATION(S)
XCOPRI, XCOPRI (250 MG DAILY DOSE), 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

PREREQUISITE THERAPY REQUIRED
YES

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
18 years of age and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an ophthalmologist, optometrist, or prescriber who specializes in the condition.

COVERAGE DURATION
6 weeks.

OTHER CRITERIA
N/A

PART B PREREQUISITE
N/A

PREREQUISITE THERAPY REQUIRED
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
Chart notes documenting diagnosis of CSD. Chart notes showing diarrhea is inadequately controlled by at least a 3-month trial of SSA therapy. Chart notes documenting an average of at least 4 bowel movements per day despite use of SSA therapy (e.g., lanreotide, octreotide). Documentation of 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

PREREQUISITE THERAPY REQUIRED
YES

XIFAXAN

MEDICATION(S)

XIFAXAN

PENDING CMS APPROVAL

XOLAIR

MEDICATION(S)

XOLAIR

PENDING CMS APPROVAL

ZEPOSIA

MEDICATION(S)
ZEPOSIA, ZEPOSIA 7-DAY STARTER PACK, ZEPOSIA STARTER KIT 0.23MG &0.46MG 0.92MG(21) CAP THPK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MS: Concomitant use with other disease-modifying agents used for MS. UC: Concomitant use with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD) or a targeted synthetic DMARD for UC.

REQUIRED MEDICAL INFORMATION
Multiple Sclerosis (MS): Documentation of diagnosis with chart notes attached. Ulcerative Colitis (UC): Documentation of diagnosis with chart notes attached. Documentation of inadequate response or intolerance to at least two of the following: an adalimumab containing agent, an infliximab containing agent, an ustekinumab containing agent, Skyrizi, Tremfya or Rinvoq.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
MS: Prescribed by or in consultation with a neurologist. UC: Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For patients new to plan with a current history of taking Zeposia in the last 90 days and for reauthorization of prior approval: Confirmation of positive clinical response.

PART B PREREQUISITE

N/A

PREREQUISITE THERAPY REQUIRED

YES

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

PREREQUISITE THERAPY REQUIRED
N/A

ZURZUVAE

MEDICATION(S)
ZURZUVAE

PENDING CMS APPROVAL

ZYMFENTRA

MEDICATION(S)

ZYMFENTRA (1 PEN), ZYMFENTRA (2 PEN), ZYMFENTRA (2 SYRINGE)

PENDING CMS APPROVAL